

APEX PHYSICAL THERAPY SPECIALISTS

Thank you for choosing APEX PHYSICAL THERAPY SPECIALISTS as your health care provider.

Consent for Treatment

I, the undersigned, hereby agree and give consent to Apex Physical Therapy Specialists to furnish care and treatment considered necessary and proper to evaluate and treat my condition. I have been informed of reason for treatment, expected benefits and risks, and alternatives. No guarantee or assurances have been made as to the results that may be obtained.

Authorization for Signature on File and Release of Information:

I, the undersigned, hereby authorize Apex Physical Therapy Specialists to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photocopy of this authorization shall be valid as an original.

I understand and give consent to Apex Physical Therapy Specialists to use/disclose my PHI (protected health information) to carry out treatment, obtaining payment and any administrative operations related to treatment or payment. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent Apex Physical Therapy Specialists may decline to provide treatment to me. Please refer to Apex Physical Therapy Specialists Notice of Privacy Practices for more complete description of such disclosures.

Authorization for Assignment of Benefits:

I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of Apex Physical Therapy Specialists and understand that I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to Apex Physical Therapy Specialists. I hereby authorize and instruct my insurance company to pay by check and mail directly to the address on file at the insurance carrier.

Deductibles/Percentage Payments and/or Co-Payments

I understand that Apex Physical Therapy Specialists will prepare insurance forms and will bill my insurance carrier directly as a courtesy. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Co-payments are expected at time of service. Patients are responsible for their insurance deductibles if applicable. Remaining balances for deductible and percentage payment amounts will be billed at the time the payment from your insurance company is received.

Insurance Changes: I understand that it is my responsibility to notify Apex Physical Therapy Specialists of ANY insurance changes (termination, change of insurance) as soon as possible or I will be responsible for the entire unpaid balance.

Charges: I understand that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for ALL costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Liens: I understand that Apex Physical Therapy Specialists DOES NOT TAKE LIENS.

Auto Injury: I understand that it is my responsibility to verify my PIP (Personal Injury Protection) Benefits with my adjustor and periodically provide information to Apex Physical Therapy. Should I exhaust my PIP Benefits I AM PERSONALLY RESPONSIBLE FOR CHARGES AND WILL PAY MY BALANCE WITHIN 30 DAYS OF NOTIFICATION. _____

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR PAYMENT OF MY ACCOUNT WITHIN 30 DAYS of notice or I may be sent to collections & I will be responsible for charges related to collections.

HIPPA

I understand that I can request the HIPPA disclosure policy at any time. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Apex Physical Therapy Specialists will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

Cancellation/No-Show Policy

I understand that I must give notice of cancelation of appointments 24 hours PRIOR to my appointment. I understand that I, not my insurance company will be billed \$25.00 if I do not show or cancel with less than 24 hours notice. Apex Physical Therapy Specialists reserves the right to remove you from the schedule following 2 late cancels or no-show appointments.

I have read and fully understand all of the information within Apex Physical Therapy Specialists' Policy document and hereby agree to comply as outlined above. By signing below I am agreeing to all of the above terms and conditions.

Patient Name:

Date:

Patient/Guardian/Responsible Party Signature:

Relation to Patient (if different)/Witness: