Source Physical Therapy & Wellness

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for **Source Physical Therapy & Wellness (SPTW)** to provide Physical Therapy care to ___________________________, which is considered medically necessary in the diagnosis & treatment of the discussed condition.

Email for Correspondence

Please provide your Email address, so we may correspond with you promptly & efficiently. This includes sending you information about your Physical Therapy appointments & case. Please Note: SPTW will not share your Email address with any third party.

E Mail Address:

Benefit Assignment / Release of Information

I, hereby assign all medical benefits to which I am entitled, including Private Health Insurance, Auto Insurance, and any other health plans, to SPTW. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all medical information necessary to secure payment by phone or in writing, for utilization and quality review purposes.

Patient/Guardian X	Date _____ / _____ / _____

Financial Policy Statement

As a courtesy to our patients, it is our policy to bill your insurance carrier and your secondary, if applicable. We are **In-Network** with most insurance plans in the region. If we are not participating with your insurance plan, we will notify you before the start of your Initial Evaluation, with an estimate of the Out-of-Network benefits. I understand that any: Co-Payment, Co-Insurance and/or Deductible is **DUE AT THE TIME OF SERVICE**. In consideration of services rendered to me by SPTW, I hereby guarantee payment for any and all services rendered to me which are not covered or allowable by insurance, together with collection costs, including attorney fees.

Patient Responsibility: ☐ **IN-NETWORK: Co-Pay $ _________ , Annual Deductible $ ____________**

☐ Out-of Network: ____________ % , after $ _________________ Deductible

YOUR PAYMENT RESPONSIBILITY: your Co-Pay or estimated patient portion will be collected at the beginning of each Physical Therapy session. Once we receive the Explanation of Benefits (EOB) from your insurance carrier, we will review the EOB to determine if there remains any un-paid Patient Balance (i.e. Co-pay or Deductible). If any Patient Balance remains, **I authorize SPTW to process that balance immediately, on the credit card on electronic file. I understand my remaining balance will be processed automatically for me & any over-payments, will be refunded to me at the end of the month.**

☐ *Initial* — I understand that if my insurance company sends me (the patient) payment directly, for Physical Therapy services that I have received, then I will promptly notify my Physical Therapist, and will be charged 100% for any outstanding charges and future charges that may incur. My initials indicate authorization to process these charge to my credit card on file

24 Hour Cancellation Policy & HIPAA Compliance

My signature below indicates my understanding that each scheduled PT session is time allotted for my care. If I do not provide at least 24 hours notice for canceled appointments, I understand that I (the patient) will be charged $ _____________ for the visit.
A SPTW Representative has also reviewed the HIPAA compliance procedures for SPTW.

Patient/Guardian X	Date _____ / _____ / _____