PHYSICAL THERAPY SERVICES

CONDITIONS OF ADMISSION

TREATMENT CONSENT:
I request and authorize the staff of Physical Therapy Service to provide me with treatment and to perform any procedures now contemplated or such additional procedures as my doctor or therapist may deem reasonable and necessary for my condition. I understand this (these) treatment(s) will be performed by an appropriately credentialed staff member employed by or acting as an agent of PTS. I further understand that I may ask and have any questions answered by my therapist pertaining to the treatments being utilized, including information about significant risks, benefits of and alternatives to the procedures. I further acknowledge my right to rescind this consent at any time.

RELEASE OF INFORMATION:
PTS may disclose all or any part of my record to any person, group or corporation which is involved in the plan of care or may be liable under a contract with PTS or with me, or my family member or with my employer for all or part of PTS's charge, including but not limited to, insurers, medical service companies, workers compensation carriers, welfare funds, or my employer. This disclosure of my record may be either in writing or by oral communication.

I authorize the Social Security Administration to disclose information regarding my Medicare coverage, including, but not limited to, verification of my Medicare number, effective dates and coverage.

The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized by the patient as patient's general agent to execute the above and accept its terms. It is further understood that this release remains in effect for one (1) year unless otherwise revoked.

Signature:_____ Date:_____
(If minor, parent or legal guardian)

MISSED APPOINTMENTS:
PTS requests a 4-hour prior notification for appointment cancellation. Missed appointments, without cancellation may result in a $25 charge.

HOME HEALTH SERVICE FOR MEDICARE BENEFICIARIES:
Outpatient physical therapy services are not covered by Medicare, if the beneficiary is also receiving Home Health services. I am NOT receiving any form of Medicare reimbursed Home Health services.

Signature:_____ Date:_____

ASSIGNMENT OF BENEFITS:
I hereby authorize _____(Insurance Company) to pay directly to Physical Therapy Services all benefits due me, if any, by reason of services described in the statements rendered. I understand that PTS has the same right as I do to appeal the carrier's determination.

Patient or Patient's Agent:_____ Date:_____

FINANCIAL RESPONSIBILITY:
I hereby accept all responsibility for treatment costs not covered or reimbursed by third party payers within ninety, (90) days of service. If my account is turned over to a collection agency for collection, a reasonable collection fee, not to exceed 10% of the balance, will be added to the balance of my account.
The undersigned certifies that he/she has received an explanation of the treatment costs and is the responsible party and accepts these terms.

Responsible Party and/or Trustee of Patient's Funds:_____ Date:_____

Witness:_____ Date:_____