Movement is freedom™

www.ALLTherapy.net

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PATIENT CONSENT AND RELEASE FORM

Please read carefully before you sign. By your signature, you acknowledge understanding of all items set forth herein. If you have questions regarding any sections, please feel free to ask the assigned outpatient representative for assistance.

CONSENT TO MEDICAL AND THERAPEUTIC SERVICES

I consent to the procedures, which may be performed during the duration of this outpatient treatment, including emergency treatment. I understand that if I fail to carry out the follow-up medical care, I do so at my own risk.

I understand that those individuals who attend to patients at this facility may include medical, nursing, and other health care personnel in training who, unless requested otherwise, may be present during patient care or may provide care as a part of their education.

I also understand that the rehabilitation process, by its very nature, involves certain inherent and unavoidable risks, including falls, and other similar injuries, and that the only alternative to entirely avoid these risks would be to forego rehabilitation altogether.

FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT AND ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare, Medicaid and/or other benefits be made on my behalf to **ALL Therapy**. I authorize ALL Therapy, if it chooses, to pursue on my behalf any appeals of the denial of my insurance benefits, and to release my medical records as required to determine benefits payable. ALL Therapy, its agents and employees are hereby released from any and all liability of any nature that may arise from the release of information.

I guarantee the payment of the full and entire amount of all bills rendered for the patient. Any amounts not paid within forty-five (45) days of any invoice of non-payment shall be subject to an interest charge of 8% per annum.

I also understand that all insurance coverage estimates quoted to me and/or other responsible party is estimated, and that I and/or other responsible party shall be liable for all charges not covered by insurance whether or not such coverage agrees with the amount estimated. I certify that I have disclosed any and all health insurance coverage information.

MANAGED CARE PLAN OBLIGATIONS

Your insurance carrier requires that you have a current and complete written referral from your primary care physician (in some instances the referring physician may be able to provide it; check with your carrier directly). If this referral is not presented prior to treatment being rendered, you insurance may not cover all or a portion of the medical expenses incurred. In this instance, you are responsible for all uncovered charges. It is also your responsibility to assist the ALL Therapy staff in obtaining additional referrals when necessary and appropriate. If you require additional or more specific information regarding your insurance coverage, please contact your carrier directly.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the ALL Therapy Notice of Privacy Practices.

Patient/Legal Guardian Signature (seal): ____ Date: ________________

Home Address: ____ Phone: _________________________

Signature of Witness: ____ Date: ________________

Completed by ALL Therapy: Acknowledgement of Notice of Privacy Practices not obtained because:

☐ Emergency Patient ☐ Patient declined to sign ☐ Patient unable to sign ☐ Other ____________________