CONSENT FOR CARE AND TREATMENT

I, the undersigned, recognize my need to receive physical therapy services from ABIY PHYSICAL THERAPY & REHAB LLC. Therefore, I do hereby give my consent for ABIY PHYSICAL THERAPY & REHAB LLC to provide me with such services considered necessary in diagnosing, treating and improving my physical condition(s).

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to ABIY PHYSICAL THERAPY & REHAB LLC. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment. Information without patient identifiers may be used for quality assurance and service improvement purposes.

CANCELLATION POLICY

Frequently cancelling appointments or not complying with your appointment schedule will directly impact your progression in therapy and our ability to accommodate other patients. For this reason, ABIY PHYSICAL THERAPY & REHAB LLC has established a 24 hour cancellation/rescheduling policy. There will be a charge of $30.00 for no show or less than 24 hours cancellation. Consideration will be made for special circumstances.

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. **All co-payments and deductibles are due at the time of service.**

Although ABIY PHYSICAL THERAPY & REHAB LLC will verify your benefits prior to treatment, the information provided to us by your insurance company is not a guarantee of payments. Your insurance company will determine what services they cover and what the payments for those services will be after they receive a claim from ABIY PHYSICAL THERAPY & REHAB LLC. You will be billed for any non-covered services and/or co-insurance payments.

If any payment is made directly to you for services billed by us, you consent to promptly remit same to ABIY PHYSICAL THERAPY & REHAB LLC.

The above does not apply for patients that are beneficiaries of Worker's Compensation. However, be advised if you claim WC benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I, _____, understand and agree 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, collection agency and attorney fees.

I understand and agree to follow all of the above polices.

_____ _____

Signature of Patient or Legal Guardian Date