Consent to treat & Authorization to release of information, Assignment of Benefits, Financial responsibility, Self-Pay

_____**TREATMENT CONSENT**: I hereby authorize AxisPro Physical Therapy, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. _____**AUTHORIZATION TO RELEASE OF INFORMATION:** I further authorize AxisPro Physical Therapy to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my treatment and to send me notices and reminders of my appointments via text messages or email. I acknowledge that AxisPro Physical Therapy is released from all legal liability that may arise from release of my medical records. _____**ASSIGNMENT OF BENEFITS:** I agree to assign my therapy benefits to AxisPro Physical Therapy for the services in which I receive and authorize my insurance carrier to make payments to AxisPro on my behalf. it is my responsibility to inform the facility of changes to my insurance and policy as well as name, address and phone changes. ______**FINANCIAL RESPONSIBILITY:** I understand that I am responsible for payment of my account and the facility. I hereby do guarantee payment in full on my account with AxisPro Physical Therapy, LLC for treatments and services rendered and does not take responsibility for negotiating settlements of disputed claims. I understand that all co-payments, deductible, and/or coinsurance is to be paid at time services are rendered. All balances that accrue after the initial insurance payment is received, is due upon receipt. If the account be referred to an attorney for collections, the undersigned agrees to pay all attorney's fees, court costs, legal and lawful collections costs in addition to all other sums due. ______**ASSIGNMENTS AND AUTHORIZATION TO BILL MEDICARE:** If I am a patient covered under Medicare/ Medicaid program, I understand that I am responsible for 20% of Medicare Part B services. I hereby assign and authorize payment to be made directly to AxisPro Physical Therapy, LLC, herein not to exceed the Facilities regular charges for this treatment. ______**SELF PAY:** It is our policy that you will be treated fairly and with respect regardless of your ability to pay for the services you received. If you don't qualify for local Health Assist programs, you'll be offered a prompt pay discount. We also provide reasonable, interest-free payment arrangements.

AxisPro Physical Therapy reserves the right to seek reimbursement from and all your insurers regardless if weather you provide us with their contact information, unless you instruct us to bill us directly. All records released require an administrative and copying fee paid to AxisPro before they are release, regardless of requestor. AxisPro Physical Therapy is HIPAA compliant with regard to information sharing polices.

By signing this document, I acknowledge that I have read, understand and agree that the information contained in this document including insurance benefits and any information I have presented to verify my own identity including my state issued driver's license, state issued photo identification card or my passport, and if applicable any information used to verify the identity of a minor beneficiary is current, correct and complete to the best of my knowledge. I agree to the financial terms stated above

X____ X____________________________________

Signature of Patient or Responsible Party Date