Name:
DOB:

CONSENT & ACKNOWLEDGEMENT

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 for further explanation.

Consent to Medical and Therapeutic Services

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

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. I accept these risks, realizing that all reasonable attempts are made to minimize them.

I consent to the use or disclosure of my protected health information by *BodySense PT, LLC* for the purpose of providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations on behalf of *BodySense PT, LLC*. I understand that my treatment is conditioned upon my consent as evidenced by my signature below.

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 *BodySense PT, LLC*. I authorize *BodySense PT, LLC*, 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. *BodySense PT, LLC,* its agents, and employees are hereby released from any and all liability of any nature that may arise from release of information.

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

Managed care obligations

Some insurance carriers require that you have a current and complete written referral from your ***primary care physician***… who may be a different person than the individual sending you to PT (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, your insurance may not cover all, or a portion, of the medical expenses incurred. In this instance, you may reschedule or assume responsibility for all uncovered charges. It is also your responsibility to assist the staff of *BodySense PT, LLC* in obtaining additional referrals when necessary and appropriate. If you require additional or more specific information regarding your insurance coverage, please contact your insurance carrier directly.

Notice of Policies & Benefit Information

I acknowledge that I have received information pertaining to both **a)** my specific insurance benefits / self-pay arrangements and **b)** the cancellation, payment, and HIPPA privacy policies of *BodySense PT, LLC.* I agree to abide by the responsibilities outlined in these documents.

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Patient/Legal Guardian Signature Date

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Witness Signature Date