CONSENT TO PHYSICAL THERAPY EVALUATION AND TREATMENT

I hereby consent to evaluation and/or treatment of my condition by a licensed physical therapist employed by or under contract with Clark Physical Therapy.

The physical therapist has explained to me the purpose of the evaluation and course of treatment. The physical therapist has informed me of the expected benefits and possible complications or discomfort, associated with physical therapy interventions such as; joint mobilization or manipulation, soft tissue work, manual therapy, electrical stimulation, ultrasound, manual traction, stretching, strengthening, exercise and/or postural correction. I have been given an opportunity to ask questions, receive education and my concerns have been answered to my satisfaction. I confirm that I have read and fully understand this consent form.

Initials: _________

Assignment of Benefits & Insurance/Financial responsibility

I hereby authorize payment from my insurance company of medical benefits for services rendered to Clark Physical therapy by an assignment of benefits. The completion of Insurance forms and the assignment of insurance benefits do not relieve the undersigned of the obligation to pay the amount owed for Physical therapy including co-pays and no-show/cancellation charges. You are responsible for amounts not covered by your Insurance. We have an arrangement with you, not your insurance company, for receipt of payment.

- Unless 100% coverage has been verified you are responsible for any charges not covered by insurance.
- If Insurance is not verified or you do not have coverage payment is due at time of service.
- Co-Pays are due at time of service
- A No call/ no show or failure to cancel an appointment without 24 hour notification will incur a $45 fee.
- Workers Compensation benefits will be verified and authorized however, this does not guarantee payment. In the event of denial, this account will become your responsibility.
- If your account gets turned over to a collection agency the undersigned will be responsible for attorney and/or collections fees.

Initials: _________

Release of Information

I hereby authorize release of information necessary to file claims with my insurance company and information to my physician. I permit a copy of this authorization to be used in place of the original.

Receipt of Privacy Practice, HIPPA & Cancellation Policy

I have received a copy of Clark Physical therapy's privacy practices, HIPPA forms and have had an opportunity to ask questions. I have acknowledged receipt and understand by signing and initialing this form I agree to be the responsible party.

Signature with date: ____

Printed name and DOB : ____