EVERGREEN PHYSICAL THERAPY SPECIALISTS

Consent For Care and Treatment

I, the undersigned, do hereby agree and give my consent for **Evergreen Physical Therapy Specialists** to furnish medical care and treatment that is considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian/Responsible Party _____Date_____

Benefit Assignment/Release of Information

I hereby assign all medical benefits to which I am entitled, including Medicare, private insurance and third party payor to **Evergreen Physical Therapy Specialists,** PC. 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.

Patient/Guardian/Responsible Party _____Date_____

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 any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to **Evergreen Physical Therapy Specialists**

The above may not apply for those considered Worker's Compensation. However be advised if your Workers Compensation Benefits are denied you will be held responsible for the total amount of charges for services rendered to you.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge $50.00 for missed appointments. Please help us serve you better by keeping scheduled appointments. Please let us know if you have any questions or concerns.

Information Privacy/HIPAA

Evergreen Physical Therapy Specialists will use your personal health information to treat you, and to receive treatment for the care we provide, and for other health care operations. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your health information.
We will always post a current notice at our facility. The undersigned acknowledges He/She has read this information.

This is not a guarantee of payment by your insurance company. If you have any questions please call your insurance service department.

Patient/Guardian/Responsible Party_____ Date_____

Center Representative Witness_____ Date_____