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 Name (Print) _____

Guardian/Responsible Party (Sign) _____ **Date**_____

Benefit Assignment/Release of Information

I hereby assign all medical benefits to which I am entitled, including Medicare, private insurance and third-party payer to **Evergreen Physical Therapy Specialists, PC**. A photocopy of this said assignee to release all information necessary, including medical records to secure payment.

Patient/Guardian/Responsible Party (Sign) _____ **Date**_____

Financial Policy Statement

Has Your Insurance Changed? YES OR NO

If your insurance has changed, please let office know at time you sign in. It is your responsibility to keep us updated of any insurance changes. 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 you 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/HIPPA

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.

Phone call/Email Policy: By signing below, you are authorizing us to call you at whatever phone number you provide, to include your home, work, and mobile phone, regarding outstanding balances and any other matters related to your treatment at our facility. EPTS will never give or sell your email address. You can unsubscribe from EPTS's occasional messages at any time. **Initial** _____

Patient/Guardian/Responsible Party (Sign) _____ **Date**_____

Center Representative Witness_____ Date_____