CONSENT FOR CARE AND TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I, the undersigned, do hereby agree and give my consent for **Rebound Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

CONSENT FOR RELEASE OF MEDICAL RECORDS: I hereby authorize my referring physician to release any of my pertinent medical information to **Rebound Physical Therapy** for use in the evaluation of my condition and the design of my individual treatment program.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Rebound Physical Therapy** to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

WORKER'S COMPENSATION CLAIMS: If you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

CANCELLATION AND NO-SHOW POLICY: When you schedule an appointment that time is reserved for you. It is your responsibility to remember and to keep **ALL** scheduled appointments. Appointment reminder cards, calls, texts, and/or emails are provided to assist you with remembering subsequent appointments. **A minimum of 24 hours' notice** is required if you are cancelling or rescheduling an appointment.

You will be charged **$25.00** for missed appointments and appointments which are cancelled with less than **24 hours** notice. **If you do not arrive to your appointments on time and are 15 or more minutes late, you are subject to having your appointment cancelled without notice.** All cancelled and missed appointments are documented in your medical record and will be charged to your account at the end of your treatment. **Initials** _____

FINANCIAL POLICY: We will bill your personal insurance carrier solely as a courtesy to you. You are ultimately responsible for your bill. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for service billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collection procedures become necessary, you will be responsible for any additional costs incurred.

PATIENT PAYMENT/COPAY/COINSURANCE/DEDUCTIBLE: Rebound Physical Therapy will bill patient or guarantor for any charges that are the patient's responsibility after receipt of the insurance company's explanation of benefits (EOB). The EOB will reflect which charges are the patient's responsibility and our billing will correspond to these amounts. All accounts are net 30 days from the date of invoice.

The above information has been explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian/Responsible Party Signature:_____ **Date:**_____