CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for ***Jimenez Physical Therapy*** to furnish medical care and treatment to ____ 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 and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payors to ***Jimenez Physical Therapy***. 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

This office will bill all PPO contracted providers – copayments and/or deductibles must be paid at time of visit.

Unpaid Co-pays will be billed to you with an additional processing fee of $25 per statement. We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated and/or remaining share be made today. Remaining balances must be paid accordingly:

Less than $500 – 60 Days
More than $500 – 90 Days

If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal ***usual and customary fee schedule***, you will be responsible for the difference remaining. Any unpaid balances after such time will be given to our collection agency with added interest.

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

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

When you pay by check, you expressly authorize ***Jimenez Physical Therapy***, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax). Please note: the above language authorizes an electronic debit to your account for the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not, however, mean that ***Jimenez Physical Therapy*** cannot collect a returned check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Information Privacy: ***Jimenez Physical Therapy*** will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed ***Notice of Privacy Practices*** to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility and have copies available for distribution. The undersigned acknowledges receipt of this information.

I understand my responsibility for the payment of my account.

Patient / Guardian / Responsible Party ________________________________ Date____/_____/______