COMPASS PHYSICAL THERAPY CONSENT TO TREATMENT

Name:_____**DOB:**_____

Notice of Privacy Practices: I acknowledge receipt of Compass Physical Therapy Privacy Policy. ***Initial:*** _____

Authorized Person(s): I authorize you to disclose information about my health, account, and/or treatment to:_____

Authorization to Release Information: I authorize the release of any medical or any other information to the Centers for Medicare and Medicaid Services (CMS), my insurance carrier(s), or other entities necessary to determine insurance benefits or benefits payable for related medical services and /or supplies provided to me by Compass Physical Therapy.

Financial Responsibility: I understand that insurance billing, including Workers Compensation Claims, is a service provided as a courtesy and that I am, at all times, financially responsible to Compass Physical Therapy. It is my responsibility to notify Compass Physical Therapy of any changes in my health care coverage. I am responsible for the entire bill or balance of the bill as determined by Compass Physical Therapy and/or my health care insurer if the submitted claims or any part of them are denied for payment. I request that payment of my services is made on my behalf to Compass Physical Therapy. I understand that Compass Physical Therapy may, during the course of treatment, recommend purchase of supply items. Supply items may or may not be covered under my insurance plan. I understand that it is my financial responsibility to pay for any item in full if it is not covered under my insurance plan. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services and supply items. I also understand that Compass Physical Therapy collects for copayments at the time of service by cash, check, credit or debit card***. If using credit or debit card, payments are processed by Bluefin Payment Systems which maintains encrypted credit card data in order to apply payments for services rendered. Checks returned for insufficient fund will be subject to $25 processing fee.***

Below is an ***estimate*** of the amount you are responsible for based on information we obtain from your insurance carrier.

Co-pay: $_____ per visit Co-Insurance: _____% per visit Remaining Deductible: _____ ***Initials:***_____

Cancellation Policy: We require 24hr notice to cancel an appointment. The fee for cancellation without proper notification is $25 per visit. After three (3) missed appointments without proper notification, Compass Physical Therapy reserves the right to discharge the patient and/or recommend alternative therapy provider.

Consent to Treatment: I consent to and authorize Compass Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating and treating my condition.

Treatment of Minor: ***(if applicable)***
I authorize Compass Physical Therapy to treat _____ (Minor's name).
I authorize above named minor to attend visits unattended by parent/guardian and sign for his/her self at subsequent appointments: *Yes / No* _____ (parent/guardian signature).

This is to verify that I have read and agree with the above:

_____ _____

Patient or Responsible Party Date

Notice of Non-Discrimination Policy: Compass Physical Therapy does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment.