EMORY CLINIC
Physical Therapy

CONSENT FOR TREATMENT, ASSIGNMENT OF MEDICAL BENEFITS AND PAYMENT RESPONSIBILIY

1. **MEDICAL CONSENT:** The undersigned herby authorizes provider to render to Patient physical therapy, occupational therapy or other related services (collectively referred to as "Services") that Provider, or Patient's treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with Provider's rendition of Services. The undersigned acknowledges that no guarantees have been made as to the results of assessment and treatment.

2. **PAYMENT FOR SERVICES:** The undersigned understands that payment is expected at the time of service for all Services. Insurance will be filed for services rendered. Patients with Medicare, Medicaid, and other Managed Care Contracts with whom we have agreements will be honored for all visits. CO-PAYS are expected at the time of service.

3. **LIABILITY CLAIMS:** Assistance will be given to provide the patient with necessary forms for filing, but payment is expected at the time of service.

4. **MEDICAL RECORDS RELEASE:** The Patient or the guarantor of the account hereby authorizes Provider to release Patient's medical record (including any information furnished to Provider or obtained by Provider in connection with Patient's treatment) to any referring physician, insurance company, health care facility or governmental agency (including the Social Security Administration or any of its intermediaries or carriers) requesting such information. Authorization is also given to release records to insurance carriers for the purpose of payment of claims including worker's compensation claims to both carrier and employer.

5. **MEDICAL INSURANCE BENEFITS:** The undersigned, hereby assigns to Provider all private medical insurance benefits (primary, secondary, and medi-gap providers) or other benefits to which Patient may be entitled for any Services rendered by Provider. The undersigned hereby authorizes and directs Provider to apply and file for all such benefits on behalf of Patient.

6. **MEDICARE AND MEDICAID AUTHORIZATION:** I certify that the information given by me in applying for payment under TITLES XVII AND IXIX of the Social Security Act is correct and I request payment of authorized benefits to be made in my behalf. I authorize Provider to release to Medicare Bureau, Health Care Financing Administration or its intermediaries or its carriers, any information about me needed for Medicare claim, including medical information for the purpose of processing a claim for Medicare benefits. I also authorize the release of medical and related information about my treatment to the utilization and quality control peer review organization responsible for reviewing the medical care furnished to me. I further state under both titles that I do not have any other insurance that is to be filed primary over my Medicare and/ or Medicaid.

7. **FINANCIAL RESPONSIBILITY:** I acknowledge full responsibility for Services rendered and agree to make definite financial arrangements for payment. I understand that the charges made for the Services may not be covered in full by my health insurance and therefore I am solely responsible for payment of all uncovered Services. I further request that payment be made directly to "Provider" according to assignment of benefits. If payment arrangements have not been made or full payment is not received in 60 days for the date of service, your account may be turned over to an attorney or collection agency. I understand that should the account be sent to an attorney or collection agency, I will be responsible for any and all extra costs or fees incurred. I understand there will be a charge of $20 for any returned checks.

8. **ACKNOWLEDGE OF RECEIPT OF PRIVACE PRACTICE NOTICE:** By signing this form you acknowledge receipt of the Notice of Privacy Practices.

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Guarantor/Patient Signature **Date**