

# *Pinnacle Physical Therapy*

## CONSENT FOR CARE AND TREATMENT

I, the undersigned, give my consent for **Pinnacle Physical Therapy**/Pinnacle Rehabilitation Network, L.L.C to furnish medical care and treatment to, \_\_\_\_\_, considered necessary and proper in diagnosing or treating his/her physical condition.

\_\_\_\_\_ **Patient/Guardian Initials**

## PRIVACY NOTICE

A copy of our Privacy Notice, which describes how your medical information may be used and disclosed, has been given to you to review. PLEASE REVIEW IT CAREFULLY. Should you want a copy, please ask the receptionist.

\_\_\_\_\_ **Patient/Guardian Initials**

## FINANCIAL POLICY STATEMENT

- We do our best to verify your insurance information as a courtesy to you. However, it is not a guarantee of payment. Co-pays will be collected at the time services are rendered. If you have co-insurance or a deductible, a bill will be sent to you for prompt payment. **Due to the fact that benefits are determined at the time the claim is processed, when payment from your insurance company is received, we will know then if it is necessary to modify your co-pay amount; or the amount to bill you for your co-insurance or deductible.**
- 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.
- If any payment is made directly to you for services billed by us, you recognize your obligation to promptly remit the same amount to Pinnacle Physical Therapy Pinnacle Rehabilitation Network, L.L.C.
- If you pay by check and your check is dishonored or returned for any reason, we will expect payment in full plus a returned check fee within 30 days of the returned check.
- 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 and attorney fees.
- **I understand that if any changes are made to my personal or insurance information while being treated it is my responsibility to inform the facility of said changes in a timely manner.**

\_\_\_\_\_ **Patient/Guardian Initials**

## BENEFIT ASSIGNMENT

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medigap, Medicaid, private insurance and third party payors to Pinnacle Physical Therapy/Pinnacle Rehabilitation Network L.L.C

**Patient/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

This information was reviewed and patient's photo ID was taken and verified that the identity of the patient is correct. \_\_\_\_\_ (staff initials)

Pinnacle Rehabilitation Network, L.L.C. Affiliate