CORNERSTONE PHYSICAL THERAPY

Consent and Statement of Financial Responsibility

Copay _____/ Deductible _____ Amount due each visit until deductible is met _____

Visit limit _____

1. **CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist and other healthcare professionals and assistants who may be involved in my care to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s) health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment. _____**INITIAL**

2. **APPOINTMENT ATTENDANCE AGREEMENT:** I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I agree to provide at least **24 hours notice** when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for any appointment will likely result in a **cancel/no show charge of $65**. Patients with a history of 2 missed appointments in a row or repeated missed/late cancellations will be discharged from our practice. _____**INITIAL**

3. **RESPONSIBILITY FOR PAYMENT:** All co-payments/coinsurance/deductible amounts are due at the time of service. I acknowledge that it is my responsibility to provide Cornerstone Physical Therapy with current insurance information and to familiarize myself with my insurance plan and its policies and that Cornerstone Physical Therapy is not responsible for interpreting these benefits or for how my insurance company processes the claims. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. If my claim is denied due to incorrect information that I have provided, I understand I will be billed and payment will be due immediately. If I have no insurance coverage or Cornerstone Physical Therapy is not contracted with my insurance, I agree to pay the balances in full at the time services are provided. If my account becomes past due, I understand that Cornerstone Physical Therapy will take the necessary steps to collect this debt. _____**INITIAL**

   Workers Compensation: We require written approval/authorization by your employer and/or workers compensation carrier. If your claim is denied, you will be responsible for payment in full. _____ **INITIAL**

   Personal Injury: We DO NOT accept liens. If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney. In addition, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. _____ **INITIAL**

4. **ASSIGNMENT OF BENEFITS:** I hereby assign to Cornerstone Physical Therapy all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits. _____ **INITIAL**

By my signature below, I certify that I have read, understand, and fully agree to **ALL** of the statements in this document and sign below freely ad voluntarily.

_____ _____

Signature of Patient or Legally Responsible Person **Date**

(By typing your name you are giving your Legal Permission for this to be used as your signature)

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Printed name of above