CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for Forged Physical Therapy to furnish medical care and treatment considered necessary and proper for diagnosing or treating his/her physical condition.

Patient/Guardian/Responsible Party _____ Date _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign to Forged Physical Therapy any insurance or other insurance company benefits that are on my behalf for any services furnished to me Forged Physical Therapy for health care services provided. I understand that Forged Physical Therapy has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Forged Physical Therapy, I agree to forward to Forged Physical Therapy all health insurance benefits and other third-party payments that I receive for services rendered to me immediately upon receipt.

Patient/Guardian/Responsible Party _____ Date _____

We will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are tendered. We require that arrangements for payment of your estimated share be made today. 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. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to Forged Physical Therapy.
The above does 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.

Your benefits have been verified on _____ - your benefits are as follows:

YOUR INSURANCE _____HAS AN INDIVIDUAL DEDUCTIBLE OF _____ WITH A FAMILY DEDUCTIBLE OF _____, OF WHICH _____ HAS BEEN MET, LEAVING _____ TO MEET YOUR DEDUCTIBLE. ONCE YOUR DEDUCTIBLE HAS BEEN MET, THE PATIENT IS RESPONSIBLE FOR A _____ COPAY, AS WELL AS _____ COINSURANCE PER VISIT. WE WILL COLLECT_____ PER VISIT UNTIL YOUR DEDUCIBLE IS MET AND _____ AFTER YOUR DEDUCTIBLE IS MET.

**The amount that is collected in office may NOT be the total balance due according to your health insurance. Your responsibility or any remaining portion thereof, as indicated by your insurance company, will be billed to you as claims process. WHEN DEDUCTIBLE APPLIES TO THE POLICY, YOU WILL RECEIVE A BILL FOR THE DEDUCTIBLE AMOUNT NOT ALREADY PAID IN THE OFFICE.

I understand and acknowledge the patient responsibility per my insurance policy. _____ (initials)**

PLEASE READ: Estimated coverage of information provided is a courtesy to our patients, but is not intended to release you from total responsibility for your account balance. This is only an estimate of the amount due from you. We encourage you to contact your insurance company if you would like to confirm your benefits. When calling please state that you are receiving 'outpatient physical therapy in an office setting CODE 11'. The contact information for your insurance policy can be located on the back of your insurance card.
The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILTY FOR THE PAYMENT OF MY ACCOUNT.**

Cancellation Policy
We reserve the right to the right to enforce a $50 cancellation/no show policy to be exercised at the discretion of Forged Physical Therapy. Failure to give advanced notice 48 hours before your appointment will be considered a cancellation.

_____ _____
Patient/Guardian/Responsible Party **Date**

_____ _____
Representative/Witness **Date**