Rehabilitation Professionals, Inc.

Consent to Treat/Financial Authorization

Patient Name: _____

1. *Consent for Treatment:*
   I hereby authorize a Rehabilitation Professionals, Inc. Physical Therapy to carry out treatment as ordered by my physician on the Plan of Treatment.

2. *Release of Information:*
   I hereby authorize a Rehabilitation Professionals, Inc. Physical Therapist to review my medical records as needed as it applies to my physical therapy treatment.

3. *Acknowledge:*
   I have been given information regarding my right of choice in obtaining physical therapy services. My choice for physical therapy is: Rehabilitation Professions, Inc.

4. *Financial Authorization:*
   REHABILITATION PROFESSIONALS, INC. MAY ACCEPT ASSIGNMENT FOR INSURANCE BENEFITS COVERING THE ABOVE SERVICES. HOWEVER, I UNDERSTAND THAT I REMAIN RESPONSIBLE FOR PAYMENTS OF SUCH CHARGES AND FOR ANY AMOUNTS STILL OWED AFTER CONSIDERATION OF BENEFITS BY ANY AND ALL THIRD PARTY PAYORS.

Medicare benefit patients will not receive a bill for any services provided unless it pertains to the purchase of supplies or to any coinsurance due. If you have supplemental insurance, claims for coinsurance will be submitted to the secondary insurance after Medicare pays their portion. In the event that Medicare or any other pay source denies payment for services rendered, the undersigned agrees to be personally and fully responsible for payment for services after notification of denial.

If you have a commercial insurance plan, you must verify your insurance coverage and benefits. Rehabilitation Professionals, Inc., will call the insurance company to verify your benefits, but will not be responsible for any misinformation supplied to us, or for any changes in coverage or benefits which may affect your balance due. If you have questions about the terms of your insurance plan, please contact the customer service number on the back of your insurance ID card.

If you become aware of any changes in your insurance coverage, you must notify Rehabilitation Professionals within three business days. Failure to do say may result in the denial of your claim.

If this treatment is the result of an employment injury, an automobile accident, or any other personal injury case, you must notify Rehabilitation Professionals PRIOR to your initial treatment. Your health insurance company may refuse to cover the cost of treatment associated with a possible third party liability. In this situation, you must file a claim with the third party insurer (for example, with Workman's Comp, or with an automobile insurance policy) and/or file a lawsuit against the party who caused your injury. Please provide that claim number and insurance company and/or lawyer contact information to us on or before your first appointment so that we can submit claims to the insurer or lawyer for payment. In the event that you are paid out of a settlement agreement, be advised that Rehabilitation Professionals holds a lien on any and all monies you receive in compensation for your injuries until such time as our charges are paid in full, to the full extent allowable by law. You are responsible for the balance due.

I hereby authorize payment of medical benefits to *Rehabilitation Professionals, Inc. (RPI)* for any services rendered. I acknowledge that I am financially responsible for any amount that is not covered by my insurance carrier (s). I understand that any unpaid balance may be referred to a collection agency for non-payment and subject to a 1.5% interest per month. In the event of a past-due balance owed, I agree to pay reasonable attorneys' fees and costs of collection including court costs to the extent limited by law. I authorize you to release to my insurance company or its agent, information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claim benefits.

Signature of Patient or Responsible Party Date

Signature of Staff Date