Consent to Treat/Release of Information

CONSENT TO EVALUATE AND TREAT
I do hereby consent to the evaluation and treatment by TwinBoro Physical Therapy Associates. I understand that it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

RELEASE OF INFORMATION
I authorize TwinBoro Physical Therapy to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third party payor (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with custodians of records. I consent to the release of medical information to ____________________________________ for communication and care coordination on by behalf.

PRIVACY PRACTICES
I acknowledge receipt of the TwinBoro Notice of Privacy Practice, which I have received at the time of this initial visit or previously.

ASSIGNMENT OF BENEFITS
I request that payment of Medicare and/or other insurance benefits be made on my behalf to TwinBoro Physical Therapy Associates for any services furnished to by TwinBoro Physical Therapy.

FINANCIAL AGREEMENT
The undersigned agrees, whether signing as agent or patient, that s/he individually obligates her/himself to pay for services rendered in accordance with the regular rates and terms of TwinBoro Physical Therapy Associates. TwinBoro will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The agent/patient is responsible for any co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility.

iNSURANCE COVERAGE
I understand that if I fail to disclose any effective insurance coverage at the time of this signing or after the first service date when said insurance became effective, I can be held responsible for any balances not covered by said insurance. This includes balances due to lack of authorization.

- ❑ I do not have secondary coverage
- ❑ I choose not to use my secondary coverage

HOME HEALTHCARE
As a Medicare beneficiary, I am aware that I can not receive physical therapy through an independent clinic if I am currently enrolled with a Home Healthcare Agency. If services were provided and I was not formally discharged by the agency, I realize that I will be held responsible for services denied by Medicare.

_________ I have received some form of home healthcare ___________ I have not received some form of home healthcare
Patient Initials Patient Initials

MEDICARE PRIMARY HORIZON BLUE CROSS BLUE SHIELD SECONDARY
Although Medicare will cover an evaluation and/or re-evaluation procedure, Horizon BCBS does not pay for these procedures. Should Horizon deny, the patient will be held responsible for the Medicare coinsurance on these and any other services Horizon deems patient responsibility.

The undersigned certifies that s/he has read, understood and accepts the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

___________________________________ ____________________________
Signature of Patient or Responsible Party Date

___________________________________ ____________________________ ________________________
Witness Date Account Number