Patient Name: _____ **Date:**_____

Do you have health insurance? (INITIAL ONE) YES _____ NO _____ LPT Employee initial _____

CONSENT FOR TREATMENT

I/We acknowledge that physical therapy services and/or treatments, to a greater or lesser degree, may result in weakness, paralysis, pain, numbness and/or limitation of movement and being mindful of such risksagree and consent to all procedures and medical services and/or treatments deemed necessary by Lewy Physical Therapy and/or the patient's physical/occupational therapist. I/We acknowledge that all information provided is made in the best professional judgment of Lewy Physical Therapy and being mindful of the uncertain nature of complicationsthat there is no guarantee, expressed or implied, as to the success or other results of the physical therapy services and/or treatments rendered.

FINANCIAL RESPONSIBILITY

I/We certify that the information provided to Lewy Physical Therapy is true and correct to the best of my knowledge and belief. In consideration of the physical therapy services and/or treatments rendered to the above named patient, I/We assume responsibility for and guarantee the payment of all service and/or treatment charges in accordance with the practice's then current rates. The patient portion of all charges is due and owing at the time services and/or treatments are rendered. The legal judicial interest rate will be added to all unpaid balances which are more than thirty (30) days delinquent. I/We also agree that, except as provided by law, I/We shall be responsible for the payment of any service and/or treatment charges which for any reason are not paid by any payer or insurance company. I also authorize Lewy Physical Therapy to initiate a complaint to the Insurance Commissioner in my name and to deposit checks made in my name. I understand if I have an unpaid balance to Lewy Physical Therapy and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximumof 35% of the debt,and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts.In order for Lewy Physical Therapy or their designated external collection agency to service my account andwhere not prohibited by applicable law, I agree that Lewy Physical Therapy and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable. I/We acknowledge that in addition to the face amount of the check, additional fines, fees and penalties will apply to all NSF and/or stop-payment checks as provided by law, including but not limited to a twenty-five ($25.00) dollars NSF service charge and/or fifteen ($15.00) dollars stop-payment service charge, and agree to pay such prior to the rendering of further physical therapy services and/or treatments. NOTICE TO PATIENTS PAYING BY CREDIT CARD - I/We authorize Lewy Physical Therapy to charge against said credit card all unpaid balances which are more than ninety (90) days delinquent, which pre-authorization will remain in effect until I/We deliver to Lewy Physical Therapy written notification of revocation in such time and manner as to afford Lewy Physical Therapy the reasonable opportunity to act upon said revocation.

MEDICAL RELEASE AND ASSIGNMENT OF INSURANCE BENEFITS

I/We authorize Lewy Physical Therapy to release all medical records, billing information and/or other protected health information, which may be of a sensitive nature to the Social Security Administration, health maintenance organizations, worker's compensation carriers, employers, or persons acting on behalf of a preferred provider arrangement (or anyof their agents or representatives), when such information is requested for payment, utilization review or coverage determination purposes. I/We understand that this authorization is strictly voluntary, that I/We may refuse to consent to such and may revoke such consent at any time, except in instances where a particular action depends upon the consent remaining in effect, including but not limited to securing full payment of the account(s). This authorization shall remain in effect for the greater of a period of not more than two (2) years from the above indicated date or until payment of this account is rendered in full. The authorization to release medical information herein contained shall also apply to all physical/occupational therapists employed by and/or contracted through Lewy Physical Therapy. I/We further authorize any such payor or insurance company to pay directly to Lewy Physical Therapy all benefits due and payable as a result of physical therapy services and/or treatments rendered by Lewy Physical Therapy. I/We hereby assign to any physical/occupational therapist providing manual and physical therapy or other services rendered in connection with this treatment, all benefits due me for such services and/or treatments under any applicable policy of insurance. I/We accept the financial responsibility to Lewy Physical Therapy and/or said physical/occupational therapist for all charges for services and/or treatments not paid by any payer or insurance company and hereby promise to pay within thirty (30) days of the date of service and/or treatmentany remaining balance.

_____ _____

Signature of patient or patient's legal Guardian **Date**

_____ _____

Relationship to patient **Signature of Witness**