Dublin Family Physical Therapy

ASSIGNMENT BY RESPONSIBLE PARTY/FILE SIGNATURE

In consideration of the medical care provided to the patient named below, I assign to Dublin Family Physical Therapy, LLC, and its Subsidiaries, the right to any medical insurance benefits to which I am or may be entitled by any health plan. ***We call on insurance benefits as a courtesy to you, but it is your responsibility to know your benefits.** This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as an original.

CONSENT TO TREAT FORM

I hereby authorize Dublin Family Physical Therapy, LLC, its Subsidiaries, and any of their representatives to provide physical therapy to myself or to any minor (under age 18) that I represent. I understand that by signing this form I am, or the minor I represent, consenting to treatment.

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand by signing this form I am authorizing Dublin Family Physical Therapy, LLC, and its Subsidiaries, to release any and all pertinent information regarding my physical therapy to my doctor, insurance company, attorney, etc.

PAYMENT POLICY

I understand that my insurance company, or Medicare, may only pay a portion of physical therapy charges. I understand that this is dependent on my specific plan of coverage. I understand that I am responsible for any balance after my insurance considers their liability. I understand that it is my responsibility to check if physical therapy is a covered item in my medical insurance plan. I also understand that I am responsible for any referrals and limitations (number of visits) that my insurance plan may have. **I agree fully and personally to be responsible for any payments that my medical insurance does not make.** I understand interest and or legal fees will be added to my balance and will also be my responsibility.

_____

Patient's Name

_____ _____

Patient's Signature (or guardian of minor) **Date**

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received the notice of Privacy Practices issued by Dublin Family Physical Therapy LLC, or one of its Subsidiaries.

I authorize Dublin Family Therapy LLC, and its Subsidiaries, to discuss my health information with the following persons:

_____ _____

_____ _____

_____ _____

Date Signature of Patient (or guardian of minor)