Dublin Family Physical Therapy

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. ***We call on insurance benefits as a courtesy to you, but it is your responsibility to know your benefits.**

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 Dublin Family Physical Therapy LLC, and its Subsidiaries, is an out of network provider of physical therapy services. I agree fully and personally to be responsible for all payments for treatments rendered by Dublin Family Physical Therapy, LLC, or one of its Subsidiaries, according to the following fee schedule if billed through insurance. My responsibility will be based off the following fee schedule, minus the amount my insurance covers per visit:

- Initial Evaluation and Treatment: $175
- 53-60 Minute Treatment Session: $159
- 38-45 Minute Treatment Session: $127
- 0-37 Minute Treatment Session: $90

I understand that if I do not have my therapy services billed through insurance then the following fee schedule will apply:

- Initial Evaluation and Treatment: $158
- 53-60 Minute Treatment Session: $143
- 38-45 Minute Treatment Session: $115
- 0-37 Minute Treatment Session: $81

Payment is due at the time of service.

_____

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