ALDERWOOD PHYSICAL THERAPY & REHAB SERVICES
PATIENT SIGNATURE FORM

Patient Name: _____

CONSENT FOR CARE

I hereby consent for care rendered by Alderwood Physical Therapy & Rehab Services. I reserve the right to refuse service at any time during the course of care. Alderwood Physical Therapy & Rehab Services does not discriminate against any person on the basis of race, color, national origin, ethnicity, religion, sex, gender identity, age or disability in admission, treatment or participation in programs, services and activities.

FINANCIAL POLICY

It is the patient's responsibility to determine what their insurance company will allow for physical therapy, obtain prior approval if necessary, and follow up with their insurance company on all unpaid visits.

Co-pays are expected at the time of service. Monthly statements will be sent when the account has a patient balance due. If you have a balance due, please make regular payments to clear the balance. Checks can be made payable to Alderwood Physical Therapy. Delinquent accounts will be assigned to a collection agency and you will incur charges for this collection action. We will be happy to assist you with insurance and/or in making payment arrangements.

MEDICAL SUPPLIES AND ORTHOTICS

Many insurance companies do not consider medical supplies a covered benefit. Therefore, we ask for payment in full at the time of pick-up if you are purchasing a non-covered item. We accept cash, check, Visa and MasterCard.

LATE CANCELATIONS AND NO SHOWS

Cancelations or changes must be made at least 24 hours in advance. A **$75.00 fee** with be charged for late cancelations or no shows. By my signature below, I acknowledge receipt of the Late Cancelation/No Show Policy (see attached).

NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge receipt of the Notice of Privacy Practices (see attached).

PATIENT'S CERTIFICATION

Authorization to Release Information and Payment Request

I certify that the information given by me in applying for payment by insurance coverage is correct. I authorize the release of all records required to act upon this request. I request that payment of authorized benefits be made on my behalf to Alderwood Physical Therapy & Rehab Services.

I hereby authorize Alderwood Physical Therapy & Rehab Services to furnish the insured's insurance company any and all information which said insurance company may request concerning my present illness or injury. I hereby assign to Alderwood Physical Therapy & Rehab Services all money to which I am entitled for medical and/or surgical expenses relative to the services performed from time to time, but not to exceed my indebtedness to said agency. It is understood that any money received from the above named insurance company, over and above my indebtedness, will be refunded when my bill is paid in full.

I understand I am financially responsible to Alderwood Physical Therapy & Rehab Services for charges not covered by this assignment, regardless of litigation, insurance reimbursement, or pending Labor & Industry claims.

I hereby authorize Alderwood Physical Therapy & Rehab Services to release any information as necessary to other health care facilities and/or their personnel.

X_____ _____
Patient Signature Date Signed

X_____ _____
Parent/Guardian Signature Date Signed