CONSENT FOR CARE AND TREATMENT

I, the undersigned, hereby give my consent for ACHIEVE THERAPY to furnish medical care and treatment that is considered necessary and proper in diagnosing or treating his/her physical condition.

Patient Name (please print) _____

Patient/Guardian Signature _____ Date ____/_____/_____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all physical therapy benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to ACHIEVE THERAPY. A photocopy of this assignment is to be considered as valid as the original. I authorize Achieve Therapy to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian Signature_____ **Date** ____/_____/_____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to ACHIEVE THERAPY.

The above does not apply to those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

When you pay by check you expressly authorize ACHIEVE THERAPY to electronically debit your account for the amount of the check. If your check is dishonored for any reason you will be charged the amount of the check plus a processing fee up to the state maximum legal limit. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not, however mean that ACHIEVE THERAPY cannot collect a returned check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

I have read the above information and agree to pay Achieve Therapy for any and all balances not covered by insurance.

_____ _____

Patient/Guardian/Responsible Party Signature Clinic Representative/Witness Signature