



MADISON

PHYSICAL THERAPY

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Madison Physical Therapy Services to furnish medical care and treatment to _____ considered necessary and proper in diagnosing and treating their physical condition.

Patient / Guardian _____ Date ____/____/____

Benefit Assignment / Release of Information

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including private insurance and any other health plans to Madison Physical Therapy Services. A photocopy of this assignment is to be considered to be as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient / Guardian _____ Date ____/____/____

Financial Policy Statement

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when services are rendered. We require payment of your estimated share be paid after each visit. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by Madison Physical Therapy Services, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Patient or Responsible Party _____ Date ____/____/____

Center Representative _____ Date ____/____/____