DYNAMIC PHYSICAL THERAPY CHICAGO

CONSENT FORM

INSURANCE: I understand that my insurance benefits are only a quote of benefits and not a guarantee of payment. I understand that what I am quoted by Dynamic Physical Therapy Chicago and/or my insurance company may differ from what I may owe at the conclusion of physical therapy.

o I understand it is my responsibility as the patient to know my insurance coverage. I authorize payment of my insurance benefits to be made directly to Dynamic Physical Therapy Chicago. I agree to pay in full any and all charges not covered by insurance or other benefits.

o I understand that it is unlawful for Dynamic Physical Therapy Chicago to waive co-pays, co-insurances, and deductibles that are my responsibility.

o If your insurance policy has changed, you have 48 hours (2 business days) following your date of service to notify us of such a change, otherwise be subject to our self-pay rates for that visit.

CONSENT: I consent to physical therapy services at Dynamic Physical Therapy Chicago. If I have any questions about my care, I will be sure to ask the physical therapist about them. It is up to me to inform the physical therapist about any health problems or allergies I have. I must also tell the physical therapist about drugs or medications I am taking.

FINANCIAL: I understand that a $25 fee will be added to my bill for any returned check. If I do not pay my outstanding balance within 60 calendar days, my balance may be sent to a collection agency. These fees will be my responsibility. If your account holds a credit, we will return your overage at the finality of your treatment.

RELEASE OF INFORMATION: Dynamic Physical Therapy Chicago releases patient health care information for purposes of treatment, payment, or to other health care organizations, as explained in our HIPAA Notice. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims & securing payment of benefits. I understand that I may deny my personal health information from anyone by submitting this in writing. Please see following for Privacy Notice.

NO GUARANTEES: I understand that the practice of physical therapy is not an exact science and that no guarantees or promises have been made to me as a result of treatments or examinations by the physical therapist. I understand that no contract, warranty, guarantee, or promise concerning the results of the physical therapy services is made. This consent to treatment form is not a contract, nor is it an offer to contract, nor is it an acceptance of an offer to contract.

NOTICE OF PRIVACY PRACTICE: I have read the Dynamic Physical Therapy Chicago Statement of Privacy Notice located on the form and I understand that a copy of the notice will be provided to me upon my request.

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CANCEL/LATE POLICY: If you must cancel your scheduled appointment, 24-hour notice is required.

o If you cancel with less than 24-hour notice, we reserve the right to charge a $50 fee. You are responsible for this fee; this cannot be billed to your insurance company.

o If you arrive more than 15 minutes late for your appointment, your therapist may refuse to treat you, or your therapy time may be reduced.

I certify that any and all information provided by me is true. I have read the information on the front and back of this form. It has been fully explained to me, if needed, and all of my questions have been answered.

_____ _____

Patient/Guardian Signature Date