Consent for Treatment

Notice of Privacy Practices is a complete description of the rights of the patients at "Raise The Bar Therapy Services LLC" Outpatient Clinic with respect to patients' information and how the patient information is protected. I have been given the opportunity to review the Notice of Privacy Practices prior to signing this consent. By signing below, I am stating I have received the Notice of Privacy Practices of RTBTS, LLC.

Patient (or authorized representative): _____

Consent for Treatment: I consent to treatment/care, as determined to be necessary, by Raise The Bar Therapy Services, LLC. I am aware that the practice of therapy is not an exact science and I understand that no guarantees have been made to me about the results of treatments or procedures.

Consent for Use and Release of Information:

I give permission to RTBTS therapists and other staff members to release any information about me, my health, the health services provided to me, or payment for my health services which may be necessary.

1. In regard to Treatment Regime: To my referring physician, any physician treating me, and or other healthcare providers or facilities which need the information to continue my care.
2. In regard to Payment: To determine my insurance eligibility, and if treatment is authorized for payment by my insurance or public benefits. Information will be used to process the claim, for utilization and quality review, or for billing collection which includes but is not limited to; medical staff, outside providers, companies billing on behalf of RTBTS.
3. In regards to the daily operations of RTBTS: To operate its business more efficiently, and to improve quality and appropriateness of care.

Financial Responsibility:

I understand and agree that:

1. The actual therapy charges for professional services performed by a licensed therapist may be different from the estimates given to me.
2. An insurance company may pay the full amount of my charges, and I may be responsible for the amount not paid.
3. I am responsible for supplying accurate information and that the insurance is filed as a courtesy and if payment is denied that balance for services rendered is my responsibility.
4. I am responsible for all copays at the time of service.
5. I understand that if a check is returned from my banking institution, an additional $25.00 processing fee will be added to my account. After 3 returned checks, RTBTS will no longer accept this method of payment for services rendered.
6. I understand that if I do not show for a scheduled appointment or do not give 24-hour notice, there will be a $25.00 No Show fee added to my account. After the third no show, I will no longer be a patient of RTBTS, treatment plan will be terminated.

Consent for Treatment Continued: Medicare/Medicaid Insurance Certification, Assignment & Payment

I have been notified that Medicare will only pay for services that are deemed necessary and appropriate, under section 1862 (a/l) of the Medicare Law. I certify that the information given in applying for payment under Titles XVIII and XIX of the Social Security Act, is correct. I request that payment of authorized benefits be made to the health care provided on my behalf. I hereby authorize Raise The Bar Therapy Services, LLC to bill for directly and assign the right to all health and liability insurance benefits otherwise payable to me and authorize direct payment to the health care system provider.

Social Security Number: I have given my social security number voluntarily. RTBTS may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

This consent will be effective for outpatient visits for one year after the date on which it is signed, unless replaced by a new consent form. It will not expire with respect to any services or processing of claims related to admissions or visits occurring while this consent is in effect.

I understand that I may withdraw this consent in writing, and my withdrawal will not be effective for actions already taken by Raise The Bar Therapy services, LLC or in process.

Raise The Bar Therapy Services, LLC is authorized to release all records required to act on these requests. I have read and understand this form, I have received a copy and I am the patient or authorized representative to act on behalf of the patient to sign this form.

Patient Signature: _____ **Date: _____**

Printed Name: _____ **Date: _____**

Relationship if not patient: _____

Witness: _____ **Date: _____**

GUARANTOR: If I sign below as a guarantor (not as the patient or spouse, or the parent of a minor child) I agree to pay all charges of RTBTS, LLC not paid, whether or not I am otherwise legally obligated to pay.

Guarantor signature: _____ **Printed Name: _____**