ProCare Physical Therapy and Hand Center, L.L.C.
General Disclosures

CONSENT FOR CARE AND TREATMENT:

I, the undersigned, do hereby agree and give my consent for ProCare Physical Therapy and Hand Center, LLC (ProCare) to furnish medical care and treatment to _____, considered necessary and proper in assessing or treating his/her physical condition. I have received a copy of the Notice of the Privacy Practices.

Patient / Guardian: _____ Date:_____

FINANCIAL POLICY STATEMENT:

_____ We do our best to verify your insurance information as a courtesy to you. However, it is not a guarantee of payment. Benefits are determined at the time the claim is processed. Co-pays and payment for supplies will be collected at the time services are rendered. Once payment from your insurance company is received, we will know if we will have to modify your co-payment. If you have a co-insurance or deductible, a bill will be sent to you for prompt payment. **We highly recommend you know your insurance benefit, and understand your policy.**

_____ If any payment is made directly to you for services billed by us, you recognize your obligation to promptly remit the same amount to ProCare Physical Therapy and Hand Center, LLC.

_____ Be advised if your claim is under Workers Compensation Benefits, and those benefits are subsequently denied, you may be held responsible for the total amount of charges for services rendered to you.

_____ Minors arriving to ProCare for treatment without parent/guardian are still responsible for co-pays at time of service. Please make arrangements to accommodate this.

_____ If you fail to show for a scheduled visit without contacting our office prior to the appointment you may be assessed a "no-show" fee of $35.00. We will provide a courtesy call to ensure continued therapy, however if you fail to show for 2 visits in a row and we are unable to contact you we will remove your remaining visits from the schedule. At which point you will need to call to reschedule further visits.

_____ If you pay by check, and the check is dishonored or returned for any reason, we will expect payment in full plus a returned check fee, if assessed, within 30 days of the returned check.

_____ **Co-insurance and deductible payments are expected within 30 days of receipt**. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I may be sent to collections and will be responsible for all costs of collecting monies owed, including court costs and attorney fees.

Patient / Guardian: _____ Date:_____

BENEFIT ASSIGNMENT:

I hereby assign all medical benefits for treatment received at ProCare to include major medical benefits to which I am entitled, including Medicare, Medigap, Medicaid, private insurance, and self payments to ProCare Physical Therapy and Hand Center, LLC.

Patient / Guardian: _____ Date:_____

CELL PHONES:

_____ As a common courtesy we request that cell phone usage by patients and guests while in ProCare be limited to texting, email, and internet use. We respectfully inform you that telephone calls (unless emergent in nature) as well as videos/music without headphones is not allowed. It is a significant distraction to patients, therapists, and office staff. Thank you