



CONSENT FOR EVALUATION, CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent to S.T.A.R. Physical Therapy & Fitness Center to furnish physical therapy evaluation, care and treatment to _____ considered necessary and proper to diagnosis or treat my/his/her physical and /or mental condition. Functionally related areas that may not be painful may also be evaluated and treated.

Patient/Client/Guardian Signature _____ Date _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, HMO, PPO, workers compensation and third party payers to S.T.A.R. Physical Therapy & Fitness Center. A duplicate NCR copy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Client/Guardian Signature _____ Date _____

FINANCIAL POLICY STATEMENT

S.T.A.R. Physical Therapy & Fitness Center will bill my insurance carrier solely as a courtesy to me. I am responsible for the entire bill when the service(s) are rendered. I will make arrangements for payment for my estimated share today. I will make all efforts to assist obtaining payments from my insurance carrier, If my insurance carrier does not remit payment within 60 days, the balance will be due in full from me. In the event that my insurance company requests a refund of payments made, I will be responsible for the amount of money refunded to my insurance company. In the event my insurance company establishes an internal usual and customary fee schedule, I will be responsible for the difference remaining. If any payment is made directly to me for services billed by S.T.A.R. Physical Therapy & Fitness Center I recognize an obligation to promptly remit same to S.T.A.R. Physical Therapy & Fitness Center.

The above does not apply for those clients care is considered by workers compensation. However, I am advised if I claim workers compensation benefits and am subsequently denied such benefits, I may be held responsible for the total amount of chargers for services rendered to me.

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. The above information has been ready by me and any questions I had have been answered. I understand my responsibility for the payment of my account.

Please notify our office 24 hours in advance if you need to cancel or reschedule an appointment. **There is a \$25.00 fee for failing to show up for a scheduled appointment, which you are personally responsible for.**

Signature of Patient/Client/Guardian/Responsible Party

Date