LAMESA PHYSICAL THERAPY
& SPORTS REHAB

**Consent for Care and Treatment, Benefit Assignment/Release of Information, Information Privacy**

I, _____, do hereby agree and give my consent for Lamesa Physical Therapy and Sports Rehab to furnish medical care and treatment to me that is considered necessary and proper in diagnosing or treatment my physical and mental condition. I hereby assign all medical to include major medical benefits to which I am entitled, including Medicare, Medicaid, and third-party payers to Lamesa Physical Therapy and Sports Rehab. A photocopy 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. Lamesa Physical Therapy and Sports Rehab will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health Care operations generally include those activities we perform to improve our quality of care. A summary of our Notice of Privacy Practices is furnished to you at the time of admit, however a complete version of our Privacy Practices is available upon request.

**Sexual harassment**

Sexual harassment is not tolerated in any form or fashion. Please refrain from any inappropriate gestures, comments, or jokes towards staff, visitors and or other patients.
Patient initials_____

**Workers Compensation**

If you are a worker's compensation patient miss an appointment not made up in the same week, we are required to communicate the missed appointment to your insurance adjuster, case manager, physician/ or employer.
Patient initials_____

**Do Not Resuscitate**

If you do not provide our facility with a copy of your DNR Form, CPR-BLS will be initiated.
Patient initials_____

**Financial Policy Statement**

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment to us within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for that amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit the payment to Lamesa Physical Therapy and Sports Rehab. The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim worker's compensation benefits and you are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you. 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. I understand what financial obligations I have, as benefits verified are done as a courtesy and is not guaranteed until claims are received at your insurance. I also understand that any charge(s) that is not covered by my insurance is my responsibility.

**I have read, understand and agree to all the above.**

_____ _____

Patient/Guardian/Responsible Party Signature Date