Patient Name: _____ Date of Birth: _____

Consent to Care and Treatment

I, the undersigned, agree and give my consent to Access Rehab Physical Therapy, PC to provide physical therapy care and treatment considered necessary and proper in treating my condition.

I further understand and agree that Access Rehab Physical Therapy, PC does not provide nor bill for any other services outside of physical therapy or its scope of practice, e.g. acupuncture services.

Authorization for Signature on File and Release of Information

I, the undersigned, authorize Access Rehab Physical Therapy, PC and his assigned billing agency service to affix my name to any and all claims or documents as related to any and all health benefits due me.

I authorize the release of any information relating to my health care claims. A photocopy of this authorization shall be as valid as an original.

Notice of Privacy Practice

I, the undersigned, hereby acknowledge that I received a copy of this Physical Therapy office's NOTICE OF PRIVACY PRACTICES.

I further acknowledge that a copy of the current notice will be in the reception area of this Physical Therapy office. If amended, I will be provided with a copy of the amended notice will also be available in the reception area updating the original.

_____ _____/_____/_____

Patient Signature Date

Patient Name: _____ Date of Birth: _____

Financial Responsibility

I, the undersigned, accept full and complete financial responsibility for all services rendered and agree to any and all insurance co-payments, deductibles, and co-insurance that may be required under the terms of my medical insurance policies, as well as pay for any medical care that is considered a "non-covered" service under the terms of my medical insurance plan.

I further acknowledge, understand, and agree, that in the event that I fail to make such payments in accordance with the payment policies of Access Rehab Physical Therapy, PC, or in the event of default of my financial obligation to pay for services rendered, Access Rehab Physical Therapy, PC may terminate the "therapist-patient" relationship.

Furthermore, in the event of my default of my financial obligation, should my account be turned over to an external collection agency for non-payment, I agree to pay any associated collection costs.

Authorization for Assignment of Benefits

I, the undersigned, assign all medical benefits, to which I am entitled, to Access Rehab Physical Therapy, PC.

In the event payment is made directly to me for physical therapy services rendered by Access Rehab Physical Therapy, PC I recognize the obligation to promptly remit payment to his office.

I hereby authorize and instruct my insurance company to pay by check and mail directly to:

ACCESS REHAB PHYSICAL THERAPY, PC
630 W ARROW HWY, SAN DIMAS, CA 91773

_____ _____/_____/_____
Patient Signature Date