Patient Name_____ DOB_____ Date_____

Energy Physical Therapy LLC – Consents and Financial Policy

Thank you for choosing Energy Physical Therapy LLC, for your physical therapy needs. We ask for your consent to treat you, release information relative to your care, and allow us to collect payments directly from your insurer. You or your legal representative must sign this consent before we begin.

Consent of Treatment and Authorization to Release information:

I hereby give consent for the provision of treatment to me or above named patient of all services ordered or deemed appropriate in diagnosing or treating my physical condition by my physician and/or physical therapist. **Initial____**

Authorization to Release Information:

I further authorize Energy Physical Therapy LLC, to release any information given in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided. **Initial____**

Authorization for Payment and Financial Responsibility:

We will directly bill your insurer for the services which we provide to you. This authorization allows us to collect payments on your behalf. As a courtesy to you, we do verify insurance to let you know what your policy covers. **Our verification process in no way guarantees payment for our service**; it your responsibility to know your insurance coverage regarding physical therapy. There are some instances where insurance may not cover all treatment charges, and you will be financially responsible to Energy Physical Therapy LLC.

- Medicare patients cannot be seen for both Part A and Part B at the same time, if you are, the financial responsibility may fall on you.

- It is a requirement by insurance companies that co-pays, if any, are to be rendered at time of service.

I certify that information provided to us is accurate. I authorize payment directly to Energy Physical Therapy LLC, any benefits payable to me and/or my qualified dependents under the insurance coverage. I agree to pay Energy Physical Therapy LLC for any medically necessary therapeutic services that are not covered by my insurance carrier. **Initial____**

Notice of Privacy Practices:

I acknowledge that I have received a copy of Energy Physical Therapy LLC Notice of Privacy Practices and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided for me. By signing below, I consent and authorize Energy Physical Therapy LLC to use and disclose my protected health information for the purposes of treatment, payment, and operation as said in the Notice of Privacy Practices. **Initial____**

Protecting your Medical Identity and Certification of Identity:

Do the risks of identity theft, we require photo identification and a current health insurance card to begin treatment. If the address on your photo ID does not match your current residence, we will also need to see a utility bill or other form of ID that shows your current address. **I certify that I am the individual I claim** to be. I understand that knowingly using another's identification under false pretense is a criminal offense. **Initial____**

I acknowledge that I read and understand all components of the Energy Physical Therapy LLC Financial Policy as stated above.

Signature of Patient or Guardian (if patient is a minor)

_____ *Date*_____

Signature of Energy Physical Therapy LLC representative

_____ Date_____ Certification of Identity_____