RestoreRehab
PHYSICAL THERAPY

664 Tenth Avenue
New York, NY 10036

Tel. 212.245.5259
Fax. 917.534.6875
info@restorerehabpt.com

www.restorerehabpt.com

PATIENT CONSENT

Patient Name _____

Routine Treatment:

Consent – I, knowing that the above named patient is in a condition requiring Physical Therapy treatment, hereby consent to rendering of routine Physical Therapy care such as Physical Modalities, Therapeutic Exercise, which may include Clinical Pilates, and Manual Therapy by a Physical Therapist and/or his/hers assistants and support personnel.

A. **Risk** – All medical care involves risk, and I acknowledge that no guarantees have been made regarding the results that can be expected from care provided at RestoreRehab Physical Therapy, PC.
B. **Right to Refuse-** I have the right to consent, or refuse consent, to any proposed procedure or therapeutic course.

RELEASE OF INFORMATION:

I authorize **RestoreRehab Physical Therapy, P.C. (RestoreRehab)** to disclose any relevant medical information such initial evaluation, treatment notes and progress notes about me, to my insurance company, family physician, referring physician and other providers involved in my care or follow up care. Additionally, from the Medical Assistance Program or to other entities that I have deemed responsible for the payment services.

FINANCIAL TERMS:

Assignment of Benefits – I give and assign to **RestoreRehab Physical Therapy, P.C.** the right to receive payment directly for all insurance and other health benefits to which I am entitled, and/ or which may be payable for the service being rendered in conjunction with this consent. I also assign payment for physical therapy services for which **RestoreRehab Physical Therapy, P.C.** is authorized to bill in connection with its services. ***I understand I am financially responsible for all charges not paid by others under this assignment.***

Medicare Benefits- (Valid only when the patient request Medicare payment for services) I request that payment of Medicare benefits be made on my behalf directly to **RestoreRehab Physical Therapy, P.C.** for any services or care provided to me. Additionally, I assign payment for physical therapy services for which **RestoreRehab Physical Therapy, P.C.** is authorized to bill in connection with its services. I authorize that **RestoreRehab Physical Therapy, P.C.** and their agents to give the Center for Medicare and Medicaid (CMS) and its agents any medical information about me (or the person I signed for) needed to determine these benefits or the benefits payable for related services. **I certify that I provided accurate information in regards to the Medicare Secondary Payer Questionnaire. Furthermore, I also acknowledge as of this date, I am not enrolled in a Medicare HMO (Health Maintenance Organization) or any other Medicare Advantage program.** I understand, I am responsible for Medicare deductibles and the twenty-percent (20%) coinsurance if I have no insurance benefits for these co-payments.

Financial Agreement – I also recognize, as the patient (responsible party/legal guardian of the patient) to whom services are being rendered, that I am ultimately responsible for all charges incurred. Furthermore, if the health insurance carrier who has been contracted to satisfy these charges on my behalf has failed to do so within forty-five (45) days *after* billing, I acknowledge that I will be required to make full payments. I hereby agree to be ultimately responsible for payment for this account unless such payment is prohibited by law or contract. Should the account be referred to any attorney for collection, I agree to pay reasonable attorney fees and collection expenses. I understand that delinquent accounts may bear interest as permitted by law.

I have read the foregoing and certify that I am the patient or am duly authorized as the patient's healthcare agent or legal guardian to execute the above and accept its terms.

RestoreRehab does not participate with all health insurance plans. If you have a health insurance plan with which RestoreRehab does not participate, you may elect to pursue physical therapy at another practice which participates with your health plan or you may chose to have it here.

- **For patient who are covered by a health plan with which RestoreRehab participates and you elect to receive services at RestoreRehab, the services will be covered and your responsibility will be limited to a co-pay, deductible and/or co-insurance, if applicable.**
- **For patients who are covered by a health plan with which RestoreRehab does not participate, if you elect to have services at RestoreRehab, you may be able to use out-of-network benefits, in which case we will submit on your behalf a claim to your health plan for physical therapy services rendered by RestoreRehab Physical Therapy, PC. You agree to remit to RestoreRehab all amounts you receive from your health plan as payment for such services together with any additional amounts due to RestoreRehab, including deductibles and co-insurance, as required by your health plan.**

_____	_____	_____
Signature of Patient	Patient's Agent or Legal Guardian (if the patient is a minor or incompetent)	Date
_____	_____	_____
Witness	Relationship to Patient	Date