PATIENT CONSENT AND RELEASE

Patient Name:_____ DOB_____
Address:_____
_____
Phone: (Home)_____ (Work)_____
(Cell)_____ (email)_____
In case of emergency contact:_____

Please read carefully before you sign. By your signature, you acknowledge understanding of all items set forth herein.

Consent to Physical Therapy Services

I give my consent to allow Cynthia Weiss, P.T. to evaluate and treat me per my diagnosis and referral from my physician. I, _____(print name), consent to the procedures which may be performed during the duration of physical therapy treatment. I understand that the rehabilitation process, by its very nature, involves certain inherent and unavoidable risks, including falls and other similar injuries, and that the only alternative to entirely avoid these risks would be to forego rehabilitation altogether.

Guarantee of Payment/Release of Information and Billing Authorization

I guarantee payment of the full amount for evaluations and treatments at the time service is rendered. I understand that Wellness Rehabilitation Inc. does not participate with my insurance company, unless I have Medicare, and I am responsible for all the charges, whether or not they are covered by my insurance. If I have Medicare, Medicare will automatically forward the claim to the secondary insurance. The secondary insurance will make the supplemental payment to the provider as stated on the explanation of benefits. Should the secondary insurance not send the payment as stated to the provider, I will be billed for that amount by the provider. I also understand should I need to cancel, **Wellness Rehabilitation Inc. requires 24 hour notice or fee for treatment will be charged.**

I authorize Wellness Rehabilitation Inc. to furnish medical records information pertaining to my diagnosis and treatment to other treating physicians, health care providers, institutions, and my insurance carriers and their agents as specified on this document. I give my consent to allow Cynthia Weiss, PT to discuss my case with my physicians and any other health care professional as needed to provide me the best quality of care.

I authorize Wellness Rehabilitation Inc. to submit bills to Medicare on my behalf and to release my medical records as required to determine benefits payable.

Insurance Information

Primary Insurance _____ Insurance Number_____
Secondary Insurance _____ Insurance Number_____

Physician Information

Name _____ Name _____
Address_____ Address_____
_____ _____
_____ _____

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (if minor) Date