PROACTIVE
Physical Therapy, PC

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Somers, NY 10589
(914)617-8211 fax (914)617-8213

proactivept@optonline.net
www.proactiveptny.com

Patient Consent

Patient Name _____ **Today's Date** _____

Consent for Care & Treatment:

I agree and give consent for Proactive Physical therapy, PC to provide care and therapy which is considered necessary and proper in diagnosing or treating my condition. To ensure maximum benefit from your therapy, it is best if you regularly attend as per your doctor's request. If you are unable to attend your scheduled appointment, kindly call the office and cancel your appointment providing us with 24 hour notice. Unattended appointments without prior notification/cancellation will incur a $25 fee to the patient's account as per our discretion.

Patient Initials _____

Financial responsibility:

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made with this office. Necessary forms will be completed to expedite insurance carrier payments.

Patient Initials _____

Assignment of Benefits:

I hereby assign all medical benefits to which I am entitled, including Medicare, private insurance, and other medical/health plans to issue payment directly to Proactive Physical Therapy, PC for all services rendered to myself and/or dependents regardless of my insurance benefit. I authorize release of all medical information necessary to process claims, including electronic means. I understand I am responsible for the amount not covered by insurance.

Patient Initials _____

Authorization to Release Information:

I hereby authorize Proactive Physical Therapy, PC to furnish and/or release any information necessary to insurance carriers, concerning my diagnosis and treatments, to process my insurance claim acquired in the course of my examination or treatment, to allow photocopy of my signature to be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked by me in writing. A photocopy of the assignments is to be considered as valid as the original. Information Privacy: Proactive Physical Therapy, PC will use and disclose your personal health information to treat you, to receive payment for the care provided, and for other health care operations to improve the quality of care. A detailed NOTICE of PRIVACY PRACTICES has been prepared to help you better understand our policies in regard to your personal health information. The terms of this notice may change. The undersigned acknowledges receipt of this information.

Patient Initials _____

I have requested medical services from Proactive Physical Therapy, PC on behalf of myself and/or my dependents. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately on presentation of the appropriate statement.

Patient/Guardian Signature _____ **Date** _____

Facility Representative/Witness Initials _____