St. John Physical Therapy, LLC

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for St. John Physical Therapy, LLC to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian/Responsible Party _____ **Date** _____

BENEFIT ASSIGNMENT /RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled private insurance, and third party payers to St. John Physical Therapy, LLC. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment

Patient/Guardian/Responsible Party _____ **Date** _____

FINANCIAL POLICY STATEMENT

We verify your insurance benefits as a courtesy to you. However, St. John Physical Therapy, LLC does not accept responsibility for any incorrect information given by your insurance carrier regarding your insurance benefits or benefit plans. We require that any co-pays that are due be paid at each visit. Once your insurance carrier processes your claim we will bill you for any remaining patient responsibility deemed by your insurance carrier. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to St. John Physical Therapy, LLC.

The above may not apply for those patients that are considered Worker's Compensation or who have benefits with a balance billing contract, such as an HMO. However, be advised if you claim Workers' Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

When you pay by check, you expressly authorize St. John Physical Therapy, LLC, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax). Please note: the above language authorizes an electronic debit to your account for the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call (888)-235-4635 to revoke the authorization for the electronic transaction. This does not, however, mean that St. John Physical Therapy, LLC cannot collect a returned check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____

Patient/Guardian/Responsible Party Date

_____ _____

Facility Representative Date