# CONSENT FOR PHYSICAL THERAPY

DATE: _____ TIME: _____

I, _____, am entering WELLSMART voluntarily for the purpose of physical therapy and do hereby consent to such treatment.

I hereby authorize WELLSMART to complete forms and release any information, be it verbal or written, including the diagnosis and records of any treatment or examination rendered to me, submitted to them in connection with physical therapy. This authorization is valid unless otherwise revoked, via written form, by me.

I agree that WELLSMART shall not be liable or responsible for the loss or damage to any articles or personal property having a monetary value.

I understand that payment in full for medical supplies is due at the time of treatment. I understand that payment in full for durable medical supplies is due prior to receipt of the equipment.

This form has been fully explained to me, and I certify that I understand its contents.

If patient is unable to consent or is a minor, complete the following:

_____ Patient named above is a minor _____ years of age.

_____ Patient named above is unable to sign because _____.
For this reason, I am signing on behalf of the patient named.

_____ _____ _____
Signature of Parent, Guardian or Closest Relative Relationship Witness

**Authorization to Release Medical Information**
I hereby authorize WELLSMART to release written or verbal information of my current treatment for the purpose of insurance billing, physician communication, or communication to a case manager, coach or athletic trainer.

**Guarantee of Account Payment**
In consideration of services rendered to this patient by WELLSMART, I/we absolutely and unconditionally guarantee the payment in full to WELLSMART of the amount due to them for the said services so rendered.

**Assignment of Benefits**
I hereby authorize payment directly to WELLSMART any medical benefits otherwise payable to me. I understand that I am financially responsible for the charges not covered by my insurance carrier.

**No-Show Fee**
I understand that if I fail to cancel a scheduled appointment within 24 hours ahead, I will be assessed a $50 fee, payable before the next treatment session. I understand that my insurance does not pay for this and that I will be responsible for this payment. Additionally, if more than 15 minutes late, due to other patient appointments, I may be required to reschedule for another time/day, counting as a “no-show” for my scheduled appointment.

**Statement to Permit Payment of Medicare Benefits to Provider, Physician and Patient**
I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information needed about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization to submit a claim to Medicare for payment to me.

I fully understand the above information:

Patient Signature _____ Date _____

Witness Signature _____ Date _____