Amherst Physical Therapy / Pinnacle Rehabilitation Network

☐ CONSENT FOR CARE AND TREATMENT

I, the undersigned, give my consent for Amherst Physical Therapy / Pinnacle Rehabilitation Network LLC to furnish medical care and treatment to, _____,considered necessary and proper in diagnosing or treating his/her physical condition. _____ **Patient/Guardian Initials**

☐ PRIVACY NOTICE

A copy of our Privacy Notice, which describes how your medical/account information may be used and disclosed, has been offered to you *and* it is posted in the facility. PLEASE REVIEW IT CAREFULLY and let us know if there are any exceptions. _____ **Patient/Guardian Initials**

☐ CANCELLATION/NO SHOW POLICY

If you need to cancel an appointment, kindly provide at least 24 hours notice so that we may offer that time to another patient. Failure to provide 24 hours notice of need to cancel an appointment, or failing to appear for a scheduled appointment (No Show) will result in a $25.00 charge. _____ **Patient/Guardian Initials**

☐ FINANCIAL POLICY STATEMENT

- We do our best to verify your plan benefits with your insurance company as a courtesy to you. However, benefits that we are quoted by your insurance company are not a guarantee of payment. Actual benefits are determined by your insurance company at the time the claim is processed. Co-pays will be collected at the time services are rendered. When payment from your insurance company is received, we will know then if we have to modify your co-pay. If you have a co-insurance, a deductible, or any other "Patient Responsibility" as determined by your insurance company, a bill will be sent to you with payment due upon receipt. By signing this document, you acknowledge that your insurance company may determine that the services provided are not covered under your policy and agree that, if your insurance company determines that any services are not covered, you shall be responsible for, and shall pay, the cost of any such services.

- If any payment is made directly to you for services billed by us, you recognize your obligation to promptly remit the same amount to Amherst Physical Therapy/ Pinnacle Rehabilitation Network, LLC.

- If you pay by check and your check is dishonored or returned for any reason, we will expect payment in full plus a returned check fee of $25.00 within 30 days of the returned check.

- 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 but not limited to collection agency fees, court costs and attorneys' fees in the amount of thirty-three percent (33%) of the total indebtedness, which may include but is not limited to all court costs and filing fees incurred by Amherst Physical Therapy/Pinnacle Rehabilitation Network, LLC.

- Be advised if you claim worker's compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

- I understand that if any changes are made to my personal or insurance information while being treated it is my responsibility to inform the facility of said changes in a timely manner.

_____**Patient/Guardian Initials**

☐ BENEFIT ASSIGNMENT

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medigap, Medicaid, private insurance and third party payors to Amherst Physical Therapy/ Pinnacle Rehabilitation Network LLC. _____**Patient/Guardian Initials**

Patient/Guardian Signature: _____ **Date** _____

Printed Name: _____

Pinnacle Rehabilitation Network, LLC Affiliate