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I-Health Physical Therapy Inc.

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent to IHealth Physical Therapy Inc to furnish medical care and treatment that is considered necessary and proper in diagnosing or treating my physical condition. However, I am aware that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and the treatment results from the rehabilitation therapy.

Signature of Patient or Guardian: _____

Date ____/____/_____

AUTHORIZATION BENEFIT ASSIGNMENT· FINANCIAL RESPONSIBILITY·RELEASE OF INFORMATION

I authorize IHealth Physical Therapy Inc to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to IHealth Physical Therapy from my insurance carrier or third-party payer.

I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between IHealth Physical Therapy Inc and me.

For Medicare patients: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.

The above may not apply for those patients that are considered Worker's Compensation. However, 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.

A photocopy of this authorization is to be considered as valid as the original.

By my signature, I authorize I Health Physical Therapy, to release all information necessary, including medical records, to secure payment.

Signature of Patient or Guardian: _____

Date ____/____/_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I have read the IHealth Physical Therapy Inc Notice of Privacy Practices. I understand that by signing this consent, I am giving my consent to IHealth Physical Therapy Inc to use and disclose my protected health information to carry out treatment, payment activities and health care operations. I understand the terms of this notice may change with time and IHealth Physical Therapy Inc will always post the current notice at the clinic, on the website and have copies available for distribution.

Indicated below are individuals whom IHealth Physical Therapy Inc may speak to regarding my treatment.
Please list names or give name of relations.

_____

We may need to contact you. Do we have your permission to leave a confidential message at the phone numbers you provide us? Please circle as appropriate.

Home Mobile Work

Signature of Patient or Guardian: _____

Date ____/____/_____