Evolution physical therapy

Consent for Treatment
Acknowledgment of Financial Responsibility

If you are covered under Medicare, Medicare will pay for reimbursable charges of our services at 80% of the covered amount. We will bill your co-insurance, or we will bill you, for the 20%. If you are covered under a different insurance policy, a copy of our Insurance Verification will be provided to you so that you are aware of the projected out of pocket expense. However, please know that verification of coverage is not an authorization for payment. We will be happy to bill your insurance company on your behalf, however, if for any reason your insurance company does not pay, the charges are your responsibility.

INSURANCE BENEFITS:

- I certify that my primary insurance is _____
- I certify that my secondary insurance is _____

FINANCIAL ACKNOWLEDGMENT:

- I acknowledge that any change to my primary or secondary insurance could affect my financial responsibility and that I will **immediately** notify Evolution Physical Therapy about the change to my primary or secondary insurance.
- I authorize payment directly to EVOLUTION PHYSICAL THERAPY due me in my pending claim and/or major medical benefits otherwise payable to me, not to exceed the charges for this period of treatment.
- I understand that if payment is issued directly to me, it is my responsibility to forward this payment to Complete Home Therapy.
- Should this account go delinquent, I agree to pay all costs of collection including collection agency fees, court costs and attorney fees.

PATIENT CONFIRMATION & CONSENT:

- I certify that I am not currently receiving any services from a home health agency or outpatient rehabilitation facility. If I purposely deceive Evolution Physical Therapy of this, then I may be held responsible for payments for services.
- I confirm that prior to starting any home health services, I will notify EVOLUTION PHYSICAL THERAPY.
- I confirm that I will notify EVOLUTION PHYSICAL THERAPY of any change to my primary or secondary insurance provider.
- I consent to treatment and to participation in this rehabilitation program.

CANCELLATION POLICY:

I will give Evolution Physical Therapy at least 12 hours notice if I need to cancel a previously scheduled appointment. _____ Canceling with in12 hours/no show will result in a $100.00 cancellation fee.

Please check box if applicable:

☐ **I have a Power of Attorney (POA) for financial decisions.** (Verbal acknowledgment of financial responsibility is required from the POA prior to evaluation for a patient who is competent, but has deferred financial decisions to a POA.)

☐ **I am the POA for this legally incompetent patient. (** A COPY OF ANY APPLICABLE POA DOCUMENTS MUST BE PROVIDED FOR THE PATIENT'S RECORD PRIOR TO EVALUATION.)

Patient Name (Print)	Signature	Date
Other Responsible Party (Print)	Signature	Date