PATIENT CONSENT AND RELEASE

Patient Name:_____ DOB_____
Address:_____
_____
Phone: (Home)_____ (Work)_____
(Cell)_____ (email)_____
In case of emergency contact:_____

Please read carefully before you sign. By your signature, you acknowledge understanding of all items set forth herein.

Consent to Physical Therapy Services

I give my consent to allow Cynthia Weiss, P.T. to evaluate and treat me per my diagnosis. I, _____(print your name), consent to the procedures which may be performed during the duration of physical therapy treatment. I understand that the rehabilitation process, by its very nature, involves certain inherent and unavoidable risks, including falls and other similar injuries, and that the only alternative to entirely avoid these risks would be to forego rehabilitation altogether.

Guarantee of Payment/Release of Information and Billing Authorization

1. I guarantee payment of the full amount for evaluations and treatments at the time service is rendered. I understand that Wellness Rehabilitation Inc. does not participate with my insurance company, and I am responsible for all the charges, whether or not they are covered by my insurance.

2. Non-Participation in Medicare and Insurance Plans: I understand that the Practice and Cynthia Weiss, PT do NOT participate or contract with any insurance plans, including, but not limited to, Health Maintenance Organizations (HMOs), Point of Service Plans (POSs), Preferred Provider Organizations (PPOs), Preferred Provider .Networks (PPNs), and that Cynthia Weiss, PT no longer accepts the Medicare Part B program. I therefore acknowledge that: (a) the Practice will bill me, and not Medicare, directly (b) payment of any additional charges is due at the time the services are rendered; and (c) I, instead of Medicare or any other insurance plan, will be fully and personally responsible for paying the Fee and any applicable additional charges. I agree not to submit the Fee or any applicable additional charges to Medicare or my insurance plan for reimbursement, and the Practice will not do so either. I understand that I may, at any point, elect to obtain medical care from a health care provider who has not opted out of the Medicare program or who participates with my Insurance plan, rather than receiving physical therapy care from the Practice.

3. Medicare Part B Beneficiaries: If I am a Medicare Part B beneficiary, or if I will become a Medicare Part B beneficiary at any time during my treatment/plan of care with Wellness Rehabilitation Inc., I also agree to the terms listed in the Medicare agreement and will sign it in addition to this Agreement to confirm my acceptance of those terms.
4. Submission of Charges to Insurance Plans: I agree not to submit a claim for any such services to Medicare Part B.

I also understand should I need to cancel, Wellness Rehabilitation Inc. requires 24 hour notice or fee for treatment will be charged.

I authorize Wellness Rehabilitation Inc. to furnish medical records information pertaining to my diagnosis and treatment to other treating physicians, health care providers, institutions, and my insurance carriers and their agents as specified on this document. I give my consent to allow Cynthia Weiss, PT to discuss my case with my physicians and any other health care professional as needed to provide me the best quality of care.

Insurance Information

Primary Insurance _____ Insurance Number_____
Secondary Insurance _____ Insurance Number_____

Physician Information

Name _____ Name _____
Address_____ Address_____
_____ _____
_____ _____

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (if minor) Date