

PRIMARY THERAPY SOURCE
CONSENT FOR TREATMENT / FINANCIAL AGREEMENT

Consent to Physical or Occupational Therapy Treatment

The undersigned voluntarily CONSENTS TO AND AUTHORIZES such physical therapy, speech therapy and/or occupational therapy evaluation and treatment as the licensed physical therapist, speech therapist and/or occupational therapist at Primary Therapy Source (PTS) considers necessary. A plan of treatment, including goals of treatment, is developed by the patient and the therapist(s) together after an initial evaluation of the problem is performed. This plan is sent to the referring physician for approval. The patient acknowledges that no guarantee has been given as to the outcome of this physical therapy, speech therapy, and/or occupational therapy plan of care.

The patient agrees to notify PTS if he/she has *previously seen* another physical/ speech/ occupational therapist for treatment of this condition *or* if he/she sees another such therapist *during treatment* with PTS.

Assignment of Insurance Benefits

In the event that the patient is entitled to insurance payments for PTS services arising out of any policy of insurance for the patient or any other party to the patient, these benefits are hereby assigned to PTS for application against the patient's bill for services. The undersigned and/or the patient agree to be responsible for any charges not covered by their insurance.

Release of Medical Records

All records obtained by PTS become part of the patient's PTS medical record. This record may contain confidential information pertaining to the patient's past medical history as well as records of the physical therapy, speech therapy, and/or occupational therapy evaluation, treatment and goals. Copies of this record are confidential and released only by a signed release from the patient. Copies of your medical records, as well as verbal discussions of your treatment, may be shared with your referring physician, other insurance carriers, or case managers as necessary for payment of services provided. All other persons requesting information will be directed to the patient for the appropriate signed release unless the law authorizes or compels PTS to release your records without a signature.

Fees for copying your records may be assessed.

Promise to Pay

For services rendered to the patient, the undersigned agrees that he/she will be fully responsible, and if married obligates the marital community, to pay the account of PTS. All account balances are due in full within 90 days of the date of service. All accounts over 90 days old will be assessed a 1.5% per month fee on the outstanding balance. Should the account be referred to an attorney for collection, the undersigned agrees to pay attorney fees and collection expenses. The venue of such action is to remain in Twin Falls County, State of Idaho without regard to the residence of the patient.

Fees will be assessed for any returned checks.

Signature of Responsible Party

Date

Patient's Name _____
(if responsible party is not the patient)

Relationship to Patient _____