SOUND BODY
REHABILITATION INC
BUILDING A BETTER YOU

CONSENT TO CARE AND TREATMENT

____ I, the undersigned, do hereby agree and give my consent to therapists at Sound Body Rehabilitation (SBR) to furnish medical care and treatment to myself/child, considered necessary and proper in diagnosing and treating my/his/her physical condition. I understand that consultation with my doctor is recommended prior to treatment.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Sound Body Rehabilitation maintains a record of the health care services provided to you. You may ask to see and obtain a copy of that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law compels us to do so. You may see your records or get more information about it by contacting Michelle McPherson at 360-769-5944. Our Notice of Privacy Practices is provided to you and describes in more detail how your health information may be used and disclosed, and how you can access your information.

BENEFITS ASSIGNMENT/RELEASE OF INFORMATION

____ I, the undersigned, do hereby assign any medical and/or surgical benefits to include major medical benefits to which I am entitled to Sound Body Rehabilitation for this physical therapy assignment. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Sound Body Rehabilitation to release all information necessary, including medical records, to secure payment for this assignment.

FINANCIAL/BILLING POLICY

It is the policy of Sound Body Rehabilitation to bill your insurance carrier as a courtesy to you. The benefits quoted to you or Sound Body Rehabilitation by your insurance company are not a guarantee of payment for our services. You are ultimately responsible for payment of all services performed, regardless of insurance payment or denial. SBR does not accept responsibility for collecting an insurance claim or for negotiating disputed claims. Co-payments and deductibles are generally due at the time of service. Late payments will incur a $5.00 service charge for each monthly billing cycle.

____ I understand that I am responsible for payment of all services performed. I am responsible for full payment of my account within 30 days. I understand that insurance reimbursement is a contract between me and my insurance company. I agree that payments for physical therapy treatment will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon. I agree that all monies I receive from any insurance company or other source for physical therapy services shall be paid immediately and applied to any unpaid balance owed to SBR. I agree that if my account has an unpaid balance for services rendered at the time of settlement or judgment for any claim I have against a third person for injury necessitating the treatment received, I will immediately pay the entire balance owing to SBR. If payments on my account are not made in a timely manner and the account becomes delinquent, the services of a collection agency or attorney on behalf of Sound Body Rehabilitation may be required. I understand I am responsible for all costs of collecting moneys owed, including court costs, collection agency fees and attorney fees.

CANCELLATION AND NO SHOW POLICY

We are committed to providing you with excellent service and care. Your appointment time is reserved for you and only you because we believe you deserve a high level of care and attention.

____ Due to the high demand for appointments, a $25.00 fee will be charged for missed appointments and appointments that are not cancelled with at least a 24 hour notice. Please note that this fee is your responsibility, not that of your insurance company. Two or more missed appointments, or appointments that are not cancelled with at least a 24 hour notice, may result in the patient being placed on a same day call-in basis for appointments. A pattern of poor attendance may result in being released from the practice and notification of such to your doctor.

I understand and agree to all of the above information and policies. I understand my financial responsibility for services rendered and for missed appointments. I hereby acknowledge receipt of the Notice of Privacy Practices.

Patient name _____ Date of Birth _____

Parent name (if a minor) _____

Signature _____ Date _____

4459 SE Mile Hill Drive, Port Orchard, WA 98366 Phone 360-769-5944/Fax 360-769-6250