FYZICAL Therapy & Balance Centers
MetroWest

CONSENT FOR TREATMENT AND CONDITIONS OF SERVICES

1. CONSENT FOR TREATMENT – I consent to the procedures performed during visits to FYZICAL Therapy and Balance Centers MetroWest ("Clinic") on an outpatient basis. All treatments and procedures are furnished under the supervision of the referring surgeon or physician, and delivered by the professional and licensed personnel of Clinic, and carried out as per the instructions of such physician and/or doctor.

2. ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO APPEAL – I hereby irrevocably assign and transfer to Clinic all rights, title, and interest in all benefits/monies payable for services and supplies rendered. Clinic may appeal on my behalf for unpaid or delayed claims; however, I understand and agree that this does not relieve me of my responsibility for any and all charges incurred.

3. FINANCIAL RESPONSIBILITY - It is agreed and understood that any financial information provided to the patient by Clinic is provided as a convenience and is not guaranteed to be accurate by Clinic or the insurance company that provided the information. The only guaranteed accurate information comes from insurance plan documents and is subject to eligibility on each date of service. It is agreed and understood that I, as the designated responsible party, am responsible for the total charges for services rendered, and I further agree that all amounts are due upon request and are payable to the clinic, and the appropriate clinicians and consultants involved in patient's care and agree to pay for any and all charges and expenses incurred or to be incurred. It is further agreed and understood that should this account become delinquent and it becomes necessary for the account to be referred to an attorney or a collection agency for collection or suit, I, as the designated responsible party or entity, shall pay all patient charges, reasonable attorney's fees and collection expenses. I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts, either current or bad debt. All delinquent accounts may be charged interest at the maximum rate allowed by law.

4. CONDITION PRECEDENT, REFERRALS, PRE-CERTIFICATION, PRE-AUTHORIZATION – It is the patient's responsibility to obtain any necessary referrals, precertification, and authorizations. I understand that failure to do so will leave me financially responsible for the charges and that obtaining these referrals/pre- certifications/authorizations does not relieve me of financial liability.

5. RELEASE OF INFORMATION / MEDICAL RECORDS – I consent and authorize Clinic to release information contained in any financial records and/or medical records to the insurance company and their representatives, any other entity responsible for payment or processing of the bills, any other facility where the patient is receiving care, and any state, federal, or other governing agency.

6. MEDICARE ANNUAL CAP AND HOME HEALTH EPISODES– Medicare places an annual limit ($2010 for 2018) on the combined total amount of physical therapy and speech therapy care that can be received. Previous therapy in this calendar year counts toward that total. If my doctor, my physical therapist, and I all agree that continued care is medically necessary, Medicare allows additional physical therapy in the dollar amount of an additional $990. I understand that if Medicare indicates I am in a home health episode during the course of my treatment, Medicare will not cover the cost of outpatient physical therapy and the claims will be my responsibility.

7. APPOINTMENT CANCEL, RESCHEDULE, AND NO SHOW – If I fail to provide 24 hours' advance notification before cancelling or rescheduling an appointment, I may be charged a $50 cancellation fee at Clinic's sole discretion. For my convenience, Clinic allows me to reschedule one cancelled appointment each week to another time within the same week with no such fee assessed, provided I do not cancel that rescheduled or another appointment that week. Other cancelled appointments should still be rescheduled, but may be subject to the cancellation fee at Clinic's sole discretion. If I fail to arrive for a scheduled appointment with no advance notification to the clinic, a $50 no-show fee will be charged. I understand that the fee is non-reimbursable by insurance and due and payable at my next visit. I understand that I may, at Clinic's sole discretion, be turned away for non-payment of these fees.

8. RETURNED CHECKS FOR INSUFFICIENT FUNDS – The return of a check (electronic or paper) issued to Fyzical Therapy and Balance Centers MetroWest will result in a $35.00 returned check fee being placed on the patient's account. The amount of the check and the $35.00 is due and payable at the next visit. The Clinic will not accept checks from a patient after a check has been returned for insufficient funds.

9. PRIVACY PRACTICE NOTIFICATION – I have received a copy of Clinic's Notice of Privacy Practices and have read the document in full. I have been given the opportunity to discuss any concerns or questions regarding this policy.

The undersigned certifies that he/she has read and verbalized/demonstrated understanding of the foregoing, received a copy thereof, and is the patient, the patient's legal representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Date	**Signature** of patient/guardian/legal representative	**Printed Name**