Active Physical Therapy
ORTHOPEDIC & SPINE REHAB

40 North Main Street
Bellingham, MA 02019
(508) 966-2717

26 Asylum Street
Milford, MA 01757
(508) 473-0400

CONSENT TO TREATMENT

I hereby authorize the professional staff at Active Physical Therapy to examine and treat me with physical therapy for the injury I have been referred here for.

_____ _____
Patient Signature Date Patient Printed Name

_____ _____
Parent or Guardian Signature (if under 18) Date Parent or Guardian Printed Name

_____
Staff Witness Signature

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

Insurance Company/Companies Name(s)_____

I hereby instruct the above named insurance company/companies to pay by check made out to and mailed directly to: _____ for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy. I understand that **Active Physical Therapy** complies with HIPPA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected.

HIPPA REGULATIONS: A photocopy of this Assignment shall be considered effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPPA guidelines.

_____ _____
Patient Signature Date Patient Printed Name

_____ _____
Parent or Guardian Signature (if under 18) Date Parent or Guardian Printed Name

_____ _____
Staff Witness Signature Date

COPAY AGREEMENT

Please speak to our front desk specialists if you have any questions regarding your appointments, insurance, financial responsibilities or any other issues. After checking with your insurance, your responsibility for services is a **$**_____ co-pay, co-insurance, or a deductible, due at the time of service. We estimate that this will be the cost per visit. **Please be advised if during the duration of therapy, your insurance policy changes you will be responsible.**

_____ _____
Patient or Guardian Date