ADVANCED
Regional Therapy

Outpatient Rehabilitation Services Agreement

PATIENT NAME: ______________________________________ **DATE OF BIRTH:** ____________________
Last First M.I.

CONSENT, CERTIFICATION, AUTHORIZATION AND RECEIPT

I consent to examinations, treatments, medications and therapeutic procedures prescribed by my physician and provided by Advanced Regional Therapy. I authorize that a photograph of myself may be taken for identification or treatment purposes only and not for release or publication.

I certify that the information provided by me is true and complete to the best of my knowledge and that no misrepresentations have been made or pertinent information intentionally omitted. I permit a copy of this authorization to be used in place of the original.

I authorize the release of information required by any third party payer regarding this or a related claim on my behalf.

I hereby certify that I have received and read the NOTICE OF PRIVACY PRACTICES from Advanced Regional Therapy.

I hereby certify that I understand that my therapy will be rescheduled if I am greater than 15 minutes late for my scheduled appointment.

I hereby certify that I understand a "no show" will result in being charged a $25.00 fee, payable at my next scheduled appointment. A "no show" is when a patient does not show up for the scheduled appointment time with no prior communication that he/she will not be fulfilling their scheduled appointment time.

I hereby certify that I understand that my therapy will be discontinued after three cancellations or no call / no shows per Advanced Regional Therapy policy, and I will need a new prescription from my physician to restart therapy.

[The following statement is applicable to Medicare and Medicaid beneficiaries only]
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the provider of services.

Date: ____________ **Signature** (patient or representative):X______________________________

[If the patient is physically or mentally incapacitated and unable to sign, the authorized representative may sign on the patient's behalf. In this event, the signature must indicate the patient's name followed by the word "by", the representative's name, relationship to the patient and the reason the patient cannot sign.]

Date: ____________ **Witness:** ______________________________

FINANCIAL AGREEMENT

For and in consideration of services rendered or to be rendered to me, I do hereby ***agree to pay to Advanced Regional Therapy*** *any and all statements rendered for such services to me. Payment shall be made within ten (10) days of receipt of statement and delinquent charges will be subject to interest penalties. I agree to pay all charges should I be deemed ineligible for payment by Medicare, Medicaid or other insurance. I authorize direct payment to Advanced Regional Therapy of all insurance benefits due and payable to me for services provided.*

Date: ____________ **Signature** (patient or representative):X______________________________

[If the patient is physically or mentally incapacitated and unable to sign, the authorized representative may sign on the patient's behalf. In this event, the signature must indicate the patient's name followed by the word "by", the representative's name, relationship to the patient and the reason the patient cannot sign.]

Date: ____________ **Witness:** ______________________________