MOUNTAIN STATES HAND & PHYSICAL THERAPY, INC

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for **Mountain States Hand & Physical Therapy, Inc.** to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical condition.

Patient/Guardian/Responsible Party_____ **Date**_____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to **Mountain States Hand & Physical Therapy, Inc.** A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Please release necessary information to insurance and/or physician: _____**Date**_____
Please DO NOT release any medical information: _____ **Date** _____

FINANCIAL POLICY STATEMENT

We bill you insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If you insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal *usual and customary fee schedule*, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to **Mountain States Hand & Physical Therapy, Inc.**

The above may not apply for those patients that are considered Worker's Compensation or who have benefits with a balance billing contract, such as an HMO. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

Mountain States Hand & Physical Therapy, Inc. verifies benefits as a **courtesy** to you. However, **Mountain States Hand & Physical Therapy, Inc.** does not accept responsibility for any incorrect information given by your insurance carrier regarding your co-pay/co-insurance benefits or benefit plans.

I am choosing to self pay for my treatment and I understand that payment is due at the time of service. _____
***OR** Please bill my insurance:* _____ *Date:* _____

When you pay by check, you expressly authorize **Mountain States Hand & Physical Therapy, Inc.,** if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax). Please note: the above language authorizes an electronic debit to your account for the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 225-4653 to revoke the authorization for the electronic transaction. This does not, however, mean that **Mountain States Hand & Physical Therapy, Inc.** cannot collect a returned check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____
Patient/Guardian/Responsible Party Date

_____ _____
Center Representative/Witness Date