Legend Oaks South Outpatient Therapy Department

Rehabilitation Services
Outpatient Therapy Treatment Agreement

This is a Therapy Treatment Agreement in which the patient consents to treatments upon the provisions hereof and the patient, responsible party, and the facility hereby agree as follows:

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Employer: _____ Work Phone: _____

Social Security #: _____ Birth Date: _____

Sex: M F (circle one)

Primary Insurance Company: _____ Group #: _____
Address: _____ Phone #: _____
Subscriber Name: _____ Co-Pay Amount: _____

Secondary Insurance Company: _____ Group #: _____
Address: _____ Phone #: _____
Subscriber Name: _____ Co-Pay Amount: _____

Physician: _____ Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____

Responsible Party: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____

Please initial each section:

_____ **Financial Responsibility:** I do hereby guarantee payment of therapy services to _____ (Facility). I understand that I am responsible for payment of my account and the facility does not accept responsibility for negotiating a settlement on a disputed claim. As a courtesy, the facility will bill my insurance. I understand that co-payments are due when services are rendered. Any balances, after initial insurance payment has been received, is due and payable upon receipt.

Patient Name: _____

Interest of 1.5% monthly (18% per annum) will be added to all accounts 30 days past due. In the event this account is placed with an attorney or collection agency for collection, the undersigned agrees to pay reasonable attorney's fees, legal expenses and lawful collection costs in addition to all other sums due hereunder.

_____ **Cancellation Policy:** 24-hour notice is required to cancel a therapy appointment. A cancellation fee of $25.00 may be charged to the responsible party if sufficient notice is not provided.

_____ **Treatment Consent:** I hereby consent to the examinations, treatments and medications ordered or recommended by my physician or designated alternate.

_____ **Authorization for Release of Information:** The institution rendering services is hereby authorized to furnish and release, in accordance with the facility's policy, such professional and clinical information as may be necessary for the completion of my medical claims by valid third party agents or agencies from the medical records compiled during treatment. The facility is hereby released from all legal liability that may arise from the release of said information.

_____ **Assignments and Authorization to Pay Insurance Benefits:** I hereby assign and authorize payment directly to the facility, herein specified and otherwise payable directly to me, but not to exceed the facility's regular charges for this period of treatment. I understand I am responsible to the facility for charges not covered or paid by my insurance.

_____ **Assignments and Authorization to Bill Medicare:** I hereby assign and authorize payment directly to this facility, herein specified and otherwise payable to me, but not to exceed the facility's regular charges for this period of treatment. I understand I am financially responsible for 20% of the Medicare Part B services.

Patient and/or responsible party agree and have received a copy of this Outpatient Therapy Agreement.

Patient: _____ Responsible Party: _____

Date: _____ Date: _____

Facility Witness: _____

Date: _____

FOR CLINIC USE ONLY:

Admission #: _____ Admission Date: _____

_____ Copy of insurance attached