InMotion
PHYSICAL THERAPY & FITNESS

CONSENT FOR CARE & TREATMENT

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

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign my medical benefits for physical therapy treatment that I receive, including Medicare, Medicaid, private insurance, and third party payers to InMotion Physical Therapy. A photocopy of this assignment (insurance card) is to be considered as valid as the original. I hereby authorize InMotion Physical Therapy to release all information necessary, including medical records, to secure payment.

FINANCIAL POLICY STATEMENT

We bill your insurance carrier as a courtesy to you. If your insurance carrier denies payment, the balance will be due in full from you.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit payment to InMotion Physical Therapy.

The above may not apply for those patients that are considered Worker's Compensation. 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.

When you pay by check, you expressly authorize InMotion Physical Therapy, if your check is dishonored or returned for any reason, to collect the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax).

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.

Information Privacy: InMotion Physical Therapy will only use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

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

InMotion Representative/Witness_____ **Date** _____