PHYSICAL THERAPY CONSENT TO TREATMENT AND AUTHORIZATIONS AND GUARANTEE

PATIENT NAME _____ START DATE OF TREATMENT _____

CONSENT TO TREATMENT: The patient and/or authorized representative of the patient, whose signature is affixed below, does hereby consent to any and all medical treatments at TriPT which may be deemed advisable by my/the patient's physicians, the intent hereof being to grant authority to administer and perform all therapies which may now or during the course of my/the patient's care be deemed advisable or necessary.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION: I hereby authorize TriPT and my therapists to release medical information contained in my/the patient's records to any necessary insurance carrier(s) and/or employer(s) and/or organizations(s), for the purpose of obtaining information and /or reviewing the record of medical care received by the patient and for the payment of all medical charges. Copies of the records may also be sent to referring physician(s) at the request of the physicians treating me/the patient. Unless noted below, medical records released may include diagnostic and therapeutic information.
Withhold from release: (please specify, if any):_____
This consent will remain in force for a reasonable time in order to collect for medical charges. This authorization is revocable except to the extent that action has been taken in reliance thereon.
Information is disclosed from records whose confidentiality is protected by Federal or State law. Federal regulations or State law prohibit making any further disclosure of HIV antibody/substance abuse information without the specific written consent of the person to whom it pertains, or as otherwise permitted by Federal/State law.

ASSIGNMENT OF INSURANCE BENEFITS: I assign payment directly to TriPT, the insurance benefits otherwise payable to me. I understand I am financially responsible to TriPT for charges not paid by this assignment and that I will assist in the collection of my insurance should there be any delay in payment. **If my insurance payment has not been received by TriPT within 30 days of billing, I agree to actively and vigorously pursue collecting the insurance payment for TriPT. If my insurance has not paid within 45 days of discharge or receipt of treatment from TriPT, I understand the entire balance becomes due. THIS ASSIGNMENT OF BENEFITS IS IRREVOCABLE.**

MEDICARE PATIENTS: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize TriPT to release to the Health Care Financing Administration or its carriers or intermediaries any information needed for this or a related Medicare claim. I hereby authorize payment, directly to TriPT, for medical benefits otherwise payable to me as a beneficiary of the Medicare Program and such other payment as may be due me from third party payers. I agree to execute such document s a may be necessary to apply for and obtain payment.

INSURANCE RECORD OF UNDERSTANDING: Your insurance company may require pre-authorization, usually through your physician, to determine which service(s) they will pay for. Your insurance company may not pay your claim or may reduce your benefits if you do not provide us with a proper authorization. As indicated on the card/document the phone number to call is _____. After the pre-authorization is obtained, additional information may be required by your insurance company for your entire visit to be covered.
(I understand that if I do not obtain the proper authorization, I will personally pay any penalty up to the total charges for the services received.)
THIRD PARTY LIABILITIES: If permitted by law and/or contract TriPT may file and enforce a lien upon third party claims to insurance.

PATIENT/GUARANTOR AGREEMENT: I/we understand that TriPT is not in the business of extending credit and therefore TriPT's policy is to require PAYMENT IN FULL AT THE TIME TREATMENT IS RENDERED. If the account is not paid in full, TriPT may add an Interest Charge of 1.5 percent per month on the unpaid balance of the account each thirty (30) day period after treatment or discharge. The minimum monthly payment stated on the periodic statement furnished to the patient/guarantor will be based on five (5%) percent of the unpaid balance of the account or $25.00, whichever is greater. If any installment is not paid within ten (10) days of due date, patient/guarantor shall pay a late charge of five (5%) percent of payment due. Maximum terms under this arrangement are twenty-four (24) months. I/we further understand that I/we may avoid paying all Service Charges by paying the entire unpaid balance at the time treatment is rendered. Due to processing costs, credit balance under $10.00 will not be refunded unless specifically requested by the guarantor. If TriPT must use the service of a collection agency or service to encourage prompt payment, a one-time collection charge of 19% of the outstanding balance may be imposed in addition to a charge of $1.05 per account, which represents the cost of collection. I/we understand the above and agree to all terms stated herein.
If more than one (1) signs this Agreement, our liability shall be joint and several. If we fail to make any payment when due hereunder TriPT may at any time, without notice or demand, institute proceedings to enforce the terms of this agreement and collect the unpaid balance of the account and should the terms of this agreement be enforced by legal process or by an attorney, I/we shall pay all costs of same, and a reasonable attorney's fee, including costs and attorney's fees on appeal. The undersigned waives an exemption from garnishment, attachment, or legal process in favor of TriPT to the extent permitted by federal or state law.
NOTICE TO GUARANTOR: Do not sign this contract before you read it or if it contains any blank spaces. You are entitled to an exact copy of the agreement you signed. The undersigned hereby acknowledges receipt of a copy of the above disclosure statement containing all information pertinent to this transaction. By signing this patient/guarantor agreement, guarantor(s) agree(s) to guaranty payment of all therapy charges incurred by patient during admission and/or service at TriPT. This is an absolute guaranty and it shall continue as long as any balance is still due and owing to TriPT.

I understand I am financially responsible for my account with TriPT, regardless of any insurance benefits.
This form is valid for care provided by TriPT for a 12 month period beginning the date of this document.
(By my signature below, I acknowledge the information located in this document.)

Patient Signature _____ Guarantor Signature [ ] Spouse [ ] Parent [ ] NOK [ ] Guardian _____ Witness _____ Date _____

Please Print _____ Please Print _____