First Coast
REHABILITATION
where patient care comes first

CONSENT AND CONDITIONS OF TREATMENT/RELEASE OF INFORMATION

I request and voluntarily consent to the receipt of the applicable standards of care used for evaluating or treating his/her medical condition. In the event of unexpected emergency, the therapy staff will initiate basic life support measures. The Fire and Rescue Department will be called to provide additional support measures and to transfer the patient to an Emergency Room if indicated. The patient's referring physician will be notified to any emergencies that may arise. In addition, I hereby release First Coast Rehabilitation of any responsibility for my personal property, which I choose to bring to therapy.

I understand that my health information is confidential but may be used or released in accordance with Federal and State laws for the purposes of treatment, payment or health care operations; such as for outcomes assessment, quality assurance, business planning/improvement activities, service providers on my evaluation and/or treatment team, utilization review organizations or agencies that provide managed care services for my insurance benefits. I know and agree that my health information may be disclosed to worker's compensation agencies, insurance companies, or employers for purposes of worker's compensation and work site safety laws. I have been provided a copy of the Privacy Notice of First Coast Rehabilitation.

INSURANCE AND FINANCIAL RESPONSIBILITY

I hereby authorize and assign payment directly to First Coast Rehabilitation for all medical and rehabilitation benefits to which I am entitled, but not to exceed my indebtedness for the treatment received. I authorize First Coast Physical Therapy to furnish my health or medical information to my treating physician(s), insurance carriers, and other payers as necessary to process claims, and obtain reimbursement or payment. In addition, I direct my insurance carriers and other payers to accept a photocopy of this assignment in lieu of the original.

I understand that I am responsible for the charges for treatment received and I agree to pay any outstanding balance, subject to applicable laws. If my account has to be referred to a collection agency, I will pay all costs of the collection, including reasonable attorney's fees.

When you miss an appointment specifically reserved for you, other patients in need of medical care cannot be seen. **We ask that you give us 24-hour notice** if it becomes necessary to change an appointment. If broken appointments exceed two incidents, we require a service fee of $25. Non-compliance with care may also result in discharge.

CO-PAYMENT / CO-INSURANCE / DECUCTIBLE INFORMATION

I understand that my insurance company requires a **co-pay** of $_____ **per visit** and that I pay a **deductible** of $_____ **before my insurance company begins to pay for services rendered**. I have been informed of this policy and understand that I am responsible for this co-payment at the time of service and that I am responsible for my deductible.

I understand that my insurance company covers _____% of reasonable and customary charges and that I am responsible for _____% of the remaining reasonable and customary charges. This estimated amount is based on information we have received from your insurance carrier and may change when paid by your insurance carrier. I understand that my final balance will result after all claims for rendered services have been submitted. I have been informed of this policy and understand that I am responsible for this co-insurance.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, BEING THE PATIENT OR OTHER PERSON LEGALLY AUTHORIZED TO ACT FOR THE PATIENT, HAVE READ THE FOREGOING, UNDERSTAND ITS CONTENT AND ACCEPT THE TERMS:

_____
Name

_____ _____
Signature of Patient/Legal Guardian Date

_____ _____
Witness Date