*PEDIATRIC THERAPY ASSOCIATES*

## CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for *Pediatric Therapy Associates* to furnish medical care and treatment to _____considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian_____ Date:_____

## BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicaid, private insurance and third party payors to *Pediatric Therapy Associates*. 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.

Patient/Guardian _____ Date: _____

## FINANCIAL POLICY STATEMENT

**We bill your 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 your 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 remit same to *Pediatric Therapy Associates.*

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.

ESTIMATED INSURANCE BENEFITS:
_____
_____

Estimated patient payment: _____
Arrangement for payment for patient's share _____

Note: Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance.

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____
Patient/Guardian/Responsible Party Date

_____ _____
Center Representative/Witness Date