Patient Name:_____

Date:_____

Patient Consent to Treat

It is the policy of Greenwood and BIG Physical Therapy to collect all known co-pays, co-insurances, and or deductibles, at the time of your visit. By obtaining services at this clinic you are agreeing to pay for supplies/services provided regardless of actual benefits paid by insurance.

I hereby authorize the staff of Greenwood/ BIG Physical Therapy to perform Physical Therapy evaluations and treatments with the understanding of the benefits and risks associated with such treatments. Furthermore, I agree and authorize my Insurance Company(s)/ responsible party(s) to pay directly to Greenwood/BIG Physical Therapy/Bohannan Irgens Group, affiliated health care provider(s) any proceeds payable under the terms of my policy for the receipt of said services. If I am a Worker's Compensation claim I will then become responsible for the amount billed. This is an irrevocable assignment and I understand, and agree, that any unpaid balance not covered under this policy is my obligation subject to an account service fee of $5/month (if not paid within 30 days of receipt), and will be paid by me. Balances not paid in full by 90 days after the first billing may be turned over to a collections agency and I agree that I am responsible to pay the additional fees levied by said agency on Greenwood/BIG Physical Therapy.

Authorizing Signature: _____ Date: _____

Notice of Privacy

I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information and have had an opportunity to review it. By signing below, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy protected health information that we may obtain.

Authorizing Signature: _____ Date: _____

Personal Representative's Name:_____

Relationship to Patient:_____

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