2001 Westown Pkwy., Suite 107
West Des Moines, IA 50265
Telephone: 515-440-3439
Fax: 515-440-3832

516 Nile Kinnick Dr. S., Suite B
Adel, IA 50003
Telephone: 515-993-5599
Fax: 515-993-1964

CONSENT TO PATIENT INTERVENTION

CONSENT TO TREATMENT: I hereby authorize the healthcare providers of **Core Physical Therapy** to administer such treatments, as they deem necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.

FINANCIAL RESPONSIBILITY: I agree that I am financially responsible for all charges relating to services rendered. I agree to pay all charges which are not covered by insurance or which are not promptly paid by the insurer. I understand and agree it is my responsibility to obtain prior approval required by my insurance and to take all other steps to qualify for insurance coverage. Balance of bill payment is due within 30 days of final payment by insurance company. ***YOU ARE ULTIMATELY RESPONSIBLE FOR PAYMENT OF ALL SERVICES.***

Accounts without payment will incur 18% per annum interest applied monthly.

I understand that if my account is escalated to a collection agency due to lack of payment, a 25% placement fee will be **added** to the balance that is forwarded to the agency.

CO-PAYMENTS ARE DUE AND PAYABLE ON THE DATE OF SERVICE*:*
We accept cash, check or credit cards, including MasterCard, Visa, American Express and Discover. A $25.00 charge will be applied for returned checks.

SELF-PAY PAYMENTS: I understand that if I am a self-pay patient, full payment is due on or before the time of service.

CANCELLATION FEE: Please help us serve you, and all Core Physical Therapy patients, better by keeping scheduled appointments. I understand that I will be responsible for a $25.00 cancellation fee if I do not cancel at least 24 hours prior to my scheduled appointment.

ASSIGNMENT OF BENEFITS: I hereby assign to **Core Physical Therapy** all insurance coverage or other benefits available under any government program, any insurance policy or plan, and any other benefit program, and I direct that all benefits be paid directly to **Core Physical Therapy**.

RELEASE OF INFORMATION: I authorize **Core Physical Therapy** to release all medical information, via facsimile or mail required by my insurance company or Worker's Compensation carrier or designee to file for medical benefits. Additionally, **Core Physical Therapy** may release information, via facsimile or mail, to any hospital or physician I may be referred from, or referred to, by **Core Physical Therapy**. Care Connection information may be used anonymously for research or publication.

_____ _____
Patient Signature Date Print Patient Name

_____
Parent/Guardian Signature Date