DOUGLAS G. DEWEY, P.T., PC.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Douglas G. Dewey, PT, OCS to furnish medical care and treatment to _____ as considered necessary and proper in treating his/her physical 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 Medicare, Medicaid, private insurance and third party payors to Douglas G. Dewey, PT, OCS. 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 RESPONSIBILITY STATEMENT

You are responsible for the entire bill, to include, but not limited to, co-payments, co-insurances and deductibles, as mandated by your insurance carrier, In the event that your insurance carrier denies payment, requests a refund of payments made or establishes an internal fee schedule, you will be responsible for the difference remaining. If bill is sent to collection to obtain payment, you will be responsible for attorney fees and costs if legal action is taken.
Your insurance company requires that we collect, at the time of service, the co-payment, co-insurance or unmet deductible amount or we could be in violation of our contract with your insurance company and risk not being reimbursed for your treatment.

Co-Payment Amount: _____/visit

Co-Insurance Amount:_____/visit

Deductible Amount: _____/year

We will accept payment from you with a check, credit card or cash. As a courtesy, we will bill your insurance company for their portion of the bill.
By signing below, I acknowledge my financial responsibility.

Patient Date

Parent/Guardian Date

Email Address:

_____

MISSED APPOINTMENTS

Unless cancelled at least **24 hours** in advance, our policy is to charge **$40.00** for missed appointments. This charge cannot be billed to your insurance company.

Patient/Parent or Guardian Date