



## CONSENT TO TREAT/FINANCIAL POLICY FORM

Please read and sign the following:

### CONSENT TO TREAT

I hereby consent to physical therapy treatment.

\_\_\_\_\_  
Patient/Guardian (if minor) Signature

\_\_\_\_\_  
Date

### FINANCIAL POLICY

I authorize the assignment of benefits for my insurance to pay Adient Health directly. I understand that I am ultimately responsible for the charges incurred for my treatment by Adient Health. I understand that the staff of Adient Health will help in billing my insurance company for payment. It is my responsibility to follow-up on any claim submitted if payment is not received in a reasonable amount of time.

I authorize the release of any and all medical information necessary to determine liability for payment and to obtain reimbursement including medical records to any person or corporation, which is or may be liable for all or any portion of charges. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediary carriers any information needed for this or related Medicare claims.

**I understand there is a \$25.00 fee for any Cancellations and / or No Shows of appointments without 24 hour notification.**

I have read and understand all of the information above, and I have completed the information to the best of my knowledge.

\_\_\_\_\_  
Patient/Guardian (if minor) Signature

\_\_\_\_\_  
Date

### CO-PAYMENT DEDUCTIBLE AGREEMENT

**I also understand that I am responsible for any co-payment and / or deductible associated with my insurance policy. I understand that I will be expected to pay my co-payment amount at time of treatment.**

My insurance benefits have been verified and it is **estimated** that my co-pay/co-insurance amount

at time of visit is \_\_\_\_\_% of Charges or \$\_\_\_\_\_. Per visit. My insurance has indicated

that I still owe a portion of my deductible. Deductible amount not met is \$\_\_\_\_\_. If I have not met my deductible requirement I agree to make payments toward meeting my deductible. I understand the co-pay/co-ins. amount is an estimate and I may be responsible for additional amount not paid by my insurance.

\_\_\_\_\_  
Patient/Guardian (if minor) Signature

\_\_\_\_\_  
Date