ABSOLUTE
PHYSICAL THERAPY

Name: _____

D.O.B.: ____/____/_____

PATIENT CERTIFICATION AND CONSENT FOR SERVICES

- I certify that the information given by me to ABSOLUTE PHYSICAL THERAPY (ABSOLUTE PT) is true and correct to the best of my knowledge.
- I assign to ABSOLUTE PT my right to benefits for services provided by ABSOLUTE PT that my insurer or another payor may be responsible for. Accordingly, I authorize that payment for those services being made directly to ABSOLUTE PT.
- I understand that, as provided for by law, ABSOLUTE PT may release my medical records to my insurer or any other payor who may be responsible for reviewing or paying for all or part of the services provided to me by ABSOLUTE PT, (or to any agent, employee or contractor of my insurer or other payor), if payment of benefits on my behalf is conditioned on receipt of those records.
- I understand that ABSOLUTE PT will make every effort to secure payment for services under any insurance coverage available to me. I understand that I am responsible for paying for any applicable copayments, deductibles or coinsurance. I also understand that I am ultimately responsible for paying in full ABSOLUTE PT billed charges for services I receive for which I have no insurance coverage, and, unless ABSOLUTE PT has agreed in writing to accept partial payment of its billed charges as payment in full, I am responsible for paying any balance due if my available coverage only partially pays for the services I receive from ABSOLUTE PT.
- Absolute PT will add an additional 35 % to any patient's bill that is turned over to collections to cover the cost of collection services..
- I understand that it is my responsibility to contact my insurance carrier to determine the coverage available for services provided by ABSOLUTE PT, and to obtain any authorizations from my insurer or referrals/orders from my Primary Care Physician I may need in order to receive benefits available under my health plan.
- I authorize the staff of ABSOLUTE PT to perform all treatments ordered by my referring physician.
- I acknowledge that I have been encouraged to ask my physical therapist if I have any questions, concerns, and/or comments regarding this certification and consent form.
- The patient must notify ABSOLUTE PT within 24 hours of their scheduled appointment if they are not going to be able to attend at either 942-2233 or 944-2941. If the **patient fails** to do so they will be required to pay a processing / room scheduling fee of **10 dollars**.

PATIENT BILL OF RIGHTS

- The patient has the right to appropriate care and to be treated with respect and consideration at all times.
- The patient has the right to refuse treatment at any time.
- The patient has the right to be informed of and to be involved in his/her diagnosis, plan of care, treatment, and prognosis at all times.
- The patient has the right to expect privacy and confidentiality with regard to treatment received at ABSOLUTE PT, except as otherwise provided above.
- The patient has the right to review and question all bills pertaining to his/her care.
- The patient has the right to voice grievances and concerns to the ABSOLUTE PT without thereby being subject to coercion, discrimination, reprisal, or interruption of service.

My signature below indicates that I have read and understand this certification and consent form, have agreed to its terms and have been provided with a copy for my records if one was desired.

Patient/Legal Guardian Signature _____ Date: _____

Printed Name: _____
(If other than patient, include relationship to patient)

Staff Signature _____ Date: _____

Printed Name and Title: _____

Original to AWPT Copy to patient