Londonderry Physical Therapy/ Pinnacle Rehabilitation Network, LLC ("Pinnacle")

Patient Name: _____ **DOB:** _____

☐ **CONSENT FOR CARE AND TREATMENT**

I, the undersigned, give my consent for "Pinnacle" to furnish medical care and treatment considered necessary and proper in diagnosing or treating his/her physical condition.

☐ **PRIVACY NOTICE**

A copy of our Privacy Notice has been offered to you. This describes how your personal medical information may be used, disclosed, and communicated which may include email or text. PLEASE REVIEW IT CAREFULLY and let us know if you require any exceptions.

Privacy Policy Exclusion: I request the following exceptions (N/A if no exceptions) _____

☐ **CANCELLATION/NO SHOW POLICY**

If you need to cancel an appointment, kindly provide at least 24 hours notice so that we may offer that time to another patient.

☐ **FINANCIAL POLICY STATEMENT**

- We have provided you the verification of benefits of your insurance coverage.
- I understand that if any changes are made to my personal or insurance information it is my responsibility to inform the facility immediately of said changes to avoid unnecessary patient balances.
- When/if Workers Compensation or Auto benefits deny or exhaust, remaining bills will be forwarded to the health insurance provided or to the patient/guarantor.
- If any payment is made directly to you for services billed by us, you recognize your obligation to promptly remit the same amount to "Pinnacle".
- Any allowed charges not covered by your insurance will be your responsibility.
- If you pay by check and your check is dishonored or returned for any reason, we will expect payment in full plus the banks returned check fee.
- When paying by credit card, I understand that the credit card processor Zirmed Inc. stores the credit card information securely. This credit card information will be used for future payments and final payment when all claims are processed. **If at any time, I want to reverse this I need to inform the facility in writing.**
- I understand and agree that if I fail to make any of the payments in a timely manner, I will be responsible for all costs of collecting monies owed, including but not limited to collection agency fees, court costs and attorneys' fees in the amount of thirty-three percent (33%) of the total indebtedness, which may include but is not limited to all court costs and filing fees incurred by "Pinnacle".

☐ **BENEFIT ASSIGNMENT**

I hereby assign all medical benefits to include major medical benefits to which I am entitled for these services including Medicare, Medigap, Medicaid, private insurance and third party payors to "Pinnacle".

I acknowledge that by signing this document I have read and understand the above and I have received copy of this form.

Patient/Guardian Signature: _____ **Date:** _____

Printed Name: _____