peterson² PHYSICAL THERAPY

ASSIGNMENT OF BENEFITS

Welcome to Peterson Physical Therapy

It is our goal to provide quality care designed to alleviate your pain and maximize your physical abilities. We will also teach you ways to care for yourself in order to prevent injuries in the future.

Today your therapist will evaluate your injury and tailor a treatment program to meet your individual needs. Together, we will set short and long term goals in an effort to facilitate your rapid recovery.

During your rehabilitation process, it is extremely important that you keep all of your appointments and follow the instructions given by your therapist. We look forward to working with you and are committed to improving your well being.

Assignment of Benefits/Authorization to release medical information

I do hereby consent to such treatment by the authorized personnel of Peterson Physical Therapy as may be dictated by prudent medical practice for my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

I, the undersigned or designated representative for the patient, do hereby assign all medical benefits of which I am entitled to Peterson Physical Therapy in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by the insurance.

After obtaining your insurance information on your initial visit, as a courtesy to our patients, our billing department will attempt to verify and explain your physical therapy benefits to you on your second or their visit to our clinic. However**, it is the patient's ultimate responsibility to know what their physical therapy benefits are by calling their insurance provider themselves or by asking a member of our billing department to explain their physical therapy benefits to them.**

I do hereby authorize Peterson Physical Therapy to release all information necessary to secure the payment of said benefits.

Thank you for allowing Peterson Physical Therapy the opportunity to serve you. If you have any questions regarding the above information or uncertainty regarding your insurance benefits, please ask for our assistance. Please sign and date this form to indicate that you understand and agree to these conditions.

This office reserves the right to charge for appointments not canceled 24 hours prior to scheduled time.

Signed_____ Date_____

Patient / Legal Guardian