Powers Physical Therapy, LLC

1247 Washington Road, Suite 24, Rye, NH 03870
Lesley Powers, PT, DPT

Consent for Care and Treatment

I, the undersigned, give my consent for Powers Physical Therapy, LLC to furnish medical care and

treatment to: ____
(Name and Date of Birth)

________________ Patient/Guardian Initials ___________________ Date

Privacy Notice

A copy of our Privacy Notice (HIPPA) has been provided to you for review. This notice describes how your medical information may be used and disclosed. After you have reviewed it carefully, please acknowledge by initialing immediately below. Copies are available upon request.

________________ Patient/Guardian Initials

Financial Policy Statement

Co-Payments

Please note: all co-payments are due at the time of service. Currently, Powers Physical Therapy, LLC only accepts check and cash payments.

Verification of Insurance

Powers Physical Therapy, LLC does its best to verify your insurance information for you; however, insurance verification is not a guarantee of payment. Ultimately, the patient is responsible for knowing the limits of their insurance coverage. This includes knowledge of deductible amounts. ***Please do your part in ensuring the most accurate coverage and payments by checking your insurance benefits with your carrier.***

Workers Compensation Claimants

If you are claiming workers compensation, please note that if claim is denied, you may be held responsible for the total amount of services rendered to you by Powers Physical Therapy, LLC.

Remittance of Insurance Payments

If any payment is made directly to you for services billed by Powers Physical Therapy, LLC and rendered here, it is your obligation to promptly remit the same amount to Powers Physical Therapy, LLC.

Returned or Dishonored Checks

If you pay by check and the check is dishonored or returned for any reason, payment in full plus the cost of the returned check fee shall be remitted to Powers Physical Therapy, LLC within 30 days.

Powers Physical Therapy, LLC

1247 Washington Road, Suite 24, Rye, NH 03870
Lesley Powers, PT, DPT

Collections

By initialing below, I understand and agree that if I fail to make any payment(s) for which I am responsible in a timely manner, that I shall pay all collections fees, court costs and attorney fees associated with the recovery of said payment(s).

Changes in Personal Information

Finally, to make sure that all the paperwork runs smoothly, please notify me of any changes or anticipated changes to your personal or insurance information while having treatment here.

Acknowledgment of Terms

___________________Patient/Guardian Initials

Benefit Assignment

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including, private insurance and third party payors to Powers Physical Therapy, LLC.

_________________Patient/Guardian Initials

24 Hour Cancellation Policy

Please know that in order to continue to provide high quality and individualized care, a $30 cancellation fee is enforced for any person who cancels with less than 24 hours notice.

_________________Patient/Guardian Initials