ASSIGNMENT OF BENEFITS STATEMENT & CONSENT FOR TREATMENT

_____ _____
Patient Account #

CONSENT FOR TREATMENT

I _____, voluntarily give my consent to the Cantrell Center for Physical Therapy and Sports Medicine, P.C. to evaluate and treat my condition, including the consent to receive telehealth services.

Authorization For Release Of Medical Information And Assignment Of Benefits

For consideration of services rendered by The Cantrell Center for Physical Therapy & Sports Medicine, P.C. I hereby guarantee payment of all charges incurred by above named patient. I hereby authorize the payment of benefits of my insurance policy to be paid directly to The Cantrell Center for Physical Therapy & Sports Medicine, P.C., for services rendered. I further authorize this office to release/receive any information acquired in the course of my examination and treatment to my insurance company, other physicians, hospital, clinics or The Cantrell Center for Physical Therapy & Sports Medicine, P.C. I authorize The Cantrell Center for Sports Medicine, P.C. to request credit information from any credit bureau.

I authorize The Cantrell Center to release information regarding my care/treatment to the following family members (spouse, children, siblings): _____

_____

It is the patient's responsibility to keep personal items with them at all times.

I also authorize The Cantrell Center to photograph me for the purpose of identity in my medical records not to be shared with any outside sources. I understand and authorize that if photos are taken of my injury during the course of treatment, that these photos can be shared with insurance carriers or attorneys if requested to insure payment and/or for educational purposes.

As a service to you, our office will bill your primary and 2nd insurance companies for charges incurred. All deductibles, co pays, and coinsurance balances will be due on the date services are rendered.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID BY MY INSURANCE COMPANY. I ALSO UNDERSTAND THAT IN THE EVENT OF DEFAULT OF PAYMENT OF MY ACCOUNT, A 30% COLLECTION FEE WILL BE ADDED TO MY OUTSTANDING BALANCE. I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR ALL ATTORNEY AND LEGAL FEES INCURRED TO COLLECT THIS BILL.

_____
PATIENT NAME (PLEASE PRINT)

_____ _____
PATIENT SIGNATURE DATE SIGNED

_____
RESPONSIBLE PARTY (if other than patient)