CONSENT FOR TREATMENT AND FINANCIAL POLICY

Patient Name: _____ DOB: _____

We would like to THANK YOU for choosing CACC. CACC accepts third party payments and will submit your bills for treatment to the address provided as a courtesy to you. In order for us to bill your insurance company on a regular basis, we request that you sign this release of information and assignment of benefits (if applicable). Typically, insurance companies pay a predetermined amount of our treatment charges; however, it is your responsibility to call your insurance company to check on the coverage provided by your individual policy. As a courtesy to you, we will perform an insurance verification with your insurance company; however, we do not take responsibility for any misinformation that we are given during this process. It is within your best interest to verify your outpatient benefits with your individual insurance plan and to confirm with our office prior to initiating treatment.

CONSENT FOR CARE AND TREATMENT

I hereby consent to the provision of treatment by CACC. I authorize CACC to furnish treatment which is considered necessary and proper in diagnosing or treating my physical condition.

It is possible that my participation in the visit could result in injury to me. I also acknowledge and fully understand that I am engaging in activities that may involve the risk of economic and other damages which might result from my own actions or omissions, from the actions or omissions of other parties, or from any of the activities I am asked to complete during this visit. I further agree that there may be other risks not known to me or not reasonably foreseeable at this time. Nonetheless, it is my desire to participate in this visit. Accordingly, I release, waive, discharge and covenant not to sue CACC, any of its employees, representatives, officers, directors, shareholders, affiliates, administrators, agents, owners, or lessors of all equipment, all of whom are hereafter referred to as "Releasees", from demands, losses or damages on account of injuries, including death or damage to property, caused or alleged to be caused in whole or in part by the negligence of the Releasees or otherwise.

I hereby authorize and designate the following individual to act in all matters in connection with my treatment by CACC, including, without limitation, discuss my therapy plan of care, and schedule and cancel my appointments

First and Last Name	Phone Number	Relationship to Patient

FINANCIAL RESPONSIBILITY

I understand that in some instances my health insurance may not cover all treatment charges incurred. I agree to be financially responsible to CACC for any medically necessary therapeutic services that are not covered by my health insurance carrier. In addition, I authorize CACC to release (a) any medical or other information about CACC services, or services provided by third parties, if required to obtain payment from my insurer or other payer and their agents to process payments; (b) any medical or other information required by my insurer, other payers and their agents; and (c) medical or other information required by my insurer, other payers and their agents, government agencies or their designees for review of the care provided to me.

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to CACC any benefits payable to me and/or my qualified dependents under the insurance coverage or Major Medical provisions of insurance coverage identified on bills submitted by CACC for treatment. By way of my signature below, I provide CACC with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment, and health care operations as described in the Notice of Privacy Practices.

CO-PAYMENTS, COINSURANCE AND DEDUCTIBLES

I understand that if my insurance plan requires a co-payment, coinsurance, and/or deductible for treatment, payment will be collected at the time of my visit, according to my insurance benefits and the following CACC policy to reduce the balance billed to me at the end of care: Copays are collected in full. $10 per visit is due **towards** 10% coinsurance, $20 per visit **towards** 20% coinsurance, etc. $50 per visit is due **towards** a deductible.

CONSENT FOR TREATMENT AND FINANCIAL POLICY

Patient Name: _____ DOB: _____

LITIGATION ACCOUNTS

With respect to litigation against another party, I understand that CACC will directly bill my appropriate insurance; however, I am responsible for the payment of my treatment, not the entity being sued. Liability action against another party will not enable me to refuse payment to CACC. I fully understand that I am directly and fully responsible to CACC for all medical bills submitted by CACC for services rendered to me regardless of whether my claims are settled or result from a court judgement.

PATIENT VALUABLES

I relieve CACC of any responsibility for loss of clothing, money, valuables, or other items that I decide to keep with me while I am a patient. I also understand that CACC will not be responsible and will not replace any property lost, broken, or stolen, which I decide to keep with me, or any property brought to me while I am a patient.

CONSENT TO RECEIVE EMAIL, TEXT MESSAGES, AND CALLS FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

I consent to receive email, text messages, and calls from CACC for my protected health care and other services at the email address and phone number(s), including my wireless number, that have been provided during the intake process. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system. I understand that providing an email address and/or phone number is not a condition of receiving treatment. I am aware that e-mail communication can be intercepted in transmission or misdirected. I also understand that I may revoke my consent for contact at any time by directly contacting CACC or utilizing the opt-out method that will be identified in the applicable communication.

MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reason(s)_____
I am entitled under State Law to consent to medical or other health services for myself, and if applicable, for my minor children without the consent of any other person: _____ Patient Initials (required if completing this section)

CERTIFICATION OF IDENTITY

I certify that I am in fact the individual I claim to be. I understand that the knowing and willful use of another individual's personal identifying information under false pretenses is a criminal offense.

FOR PHOENIX PHYSICAL THERAPY OFFICE USE ONLY

Verification of the identity of the above-named party was made by:

☐ Current Driver's License or other Photo ID

☐ Current Health Insurance Card

☐ Other:

I have read this Consent for Treatment and Financial policy form or have had it read to me, and it has been explained to my satisfaction. I understand that this consent for Treatment, Payment and Health Care Operations form may be valid for up to one (1) year from the date that I sign it and applies to all CACC facilities.

_____ _____

Signature of Patient or Guardian (if patient is a minor) **Date**

_____ _____

Signature of CACC Representative **Date**