Name:_____

DOB:_____

CORNERSTONE PHYSICAL THERAPY
5300 Westview Dr., Suite 108
Frederick, MD 21703
Phone: (301) 732-4754 Fax: (301) 732-5702
Visit us at: www.cornerstonept.net

CONSENT AND FINANCIAL RESPONSIBILITY DATE: _____

1. **CONSENT FOR TREATMENT**: I have been allowed my free choice in the selection of a therapy provider and have been allowed to exercise that free choice. I have been informed of the nature and purpose of medical treatment, procedures and services to be provided to me at this clinic and of the risks involved. I have also been informed about alternative treatments, procedures and services. I have had the opportunity to ask questions of my physician, therapist and of the staff at Cornerstone Physical Therapy. I voluntarily consent to receive therapy services.

2. **DECISIONS ABOUT CARE**: I have received information and instructions concerning my rights to make decisions about my health care, including the right to accept or refuse treatment.

3. AUTHORIZATION FOR RELEASE OF INFORMATION: I understand that all information concerning my care is confidential. I authorize Cornerstone Physical Therapy to release to my physician, other health care providers and to my payor any information related to the provision of services that may have an effect on continuation of plan of care or on the benefits payable for services rendered. This may include photographs/other personal data. I also authorize the release of information for purposes of utilization, review, medical records audits, quality improvement, and accreditation or similar reviews.

4. ASSIGNMENT OF BENEFITS: I authorize payment directly to Cornerstone Physical Therapy of health insurance benefits otherwise payable to me, but not to exceed the balance due for the outpatient therapy services provided to me. As a patient or guarantor I am responsible for any charges billed for products or services provided to me and are not reimbursed by my insurance carrier. This may include non-covered services/supplies, deductibles, co-pays, co-insurance or balances stipulated by my insurance plan. I will pay outstanding account balances in accordance with rates and terms of Cornerstone Physical Therapy. I will be responsible for any attorney or collections fees incurred by Cornerstone Physical Therapy in an attempt to collect a delinquent balance due. I certify all information provided by me in applying for Medicare payment or any other payor information is correct.

5. FINANCIAL RESPONSIBILITY: I will be responsible for informing Cornerstone Physical Therapy of any insurance/payor information changes occurring while services are being rendered. I understand that failure to do so may result in my insurance/payor denying coverage of services, products, medications or equipment of which I could ultimately be responsible.

6. PRIMARY INSURANCE: Based upon insurance information I have provided Cornerstone Physical Therapy, I understand that the following insurance benefit information for services requested has been confirmed through my insurance payor: _____.

	SERVICES	**BENEFITS**	**PATIENT RESPONSIBILITY**
Intermittent Services PT, OT, ST (circle one)			
Your secondary insurer: _____ will be billed for charges not covered by your Primary Insurance			
Prepared By: (Signature)	DATE	PATIENT SIGNATURE:	DATE
Witness: (Signature)	DATE	RESPONSIBLE PARTY:	DATE
		RELATIONSHIP IF OTHER THEN PATIENT:	