Jennifer M. Hays, M.P.T.

10442 Ridgefield Parkway
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Phone: 804-325-1483
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CONSENT FOR CARE AGREEMENT

I, the undersigned, do hereby agree and give my consent for Physical Therapy & Wellness of Richmond

to furnish medical care and treatment to ______________________________ which is
(Name of Patient)
considered necessary and proper in the diagnosing or treating my (their) physical condition.

Signature______________________________ Date______________________________
Patient/Guardian

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned, hereby assign all medical benefits, including Medicare, private insurance, major medical benefits, Worker's Compensation and any other health plans to which I am entitled to Physical Therapy & Wellness of Richmond. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Physical Therapy & Wellness of Richmond to release all medical information and records as necessary to secure payment for services rendered.

Signature______________________________ Date______________________________
Patient/Guardian

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the bill when services are rendered. Required co-payments and estimated co-insurances are to be made as services are rendered and arrangements are to be made for payment of all amounts not covered by your medical benefits or estimated co-insurances as soon as those amounts are known. If your medical benefits are not paid within sixty (60) days, the balance will be due in full from you.

All co-insurance percentages paid at the time of service are estimated. Your actual liability may be more. You are responsible for any difference between the estimated and actual co-insurance due.

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If any payments of medical benefits are made directly to you for services rendered by Physical Therapy & Wellness of Richmond, you must promptly remit such payment directly to Physical Therapy & Wellness of Richmond.

If you do not have health care benefits, you are required, and you agree, to pay at the time of service, all charges as well as any outstanding balances. Patients that elect to be "self-pay" are expected to pay at the time of service.

If you are a Worker's Compensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for your charges if you Worker's Compensation claim is successfully controverted.

If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees and/or a reasonable attorney fee.

For your convenience, we accept cash, checks and credit/debit cards. If you pay by check, and your check is returned for any reason, we will expect payment in full plus a return check fee of $30.00 with in 30 days of the returned check.

CANCELLATION POLICY

I understand that I may not miss any scheduled appointment without 24-hour prior notification to Physical Therapy & Wellness of Richmond. If I do not show for an appointment or do not give 24-hour notice, I understand that I will be charged a fee of $90.00. If applicable, my attorney or worker's compensation case manager will be notified.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Signature ______________________________ Date ______________________________
Patient/Guardian

01/2012