

# IHPT

## Hand and Physical Therapy, Inc.

### CONSENT FOR EVALUATION, CARE, AND TREATMENT

I, the undersigned, do hereby agree and give my consent to Industrial Hand and Physical Therapy, Inc. to furnish physical/occupational therapy evaluation, care, and treatment to

Considered necessary and proper in assisting the physician to diagnosis or treat my/his/her physical an/or mental condition. This may include: modalities of hot/cold pack, mechanical/manual cervical/pelvic traction, electrical muscle stimulation, vasopneumatic device, paraffin bath, whirlpool, iontophoresis with dexamethazone, contrast bath, ultrasound with/without electrical stimulation/hydrocortisone crème, therapeutic exercises, neuromuscular-education, aquatic therapy with exercises, gait training, massage, joint/soft tissue mobilization, myofascial release technique, manual lymphatic drainage, orthotic fitting/training, therapeutic activities, self care/home management training, community/work integration, muscle testing, range of motion test, somatosensory test, work hardening/conditioning, prosthetic training, wheelchair management/propulsion training, development of cognitive skills, transcutaneous electrical nerve stimulation, procedure of wound care, dressing changes, accupressure over trigger point, strain/counterstrain, stress loading, adaptive equipment, joint protection techniques, and use of therapy exercise equipment; supplies and materials as needed. Your care may include evaluation and treatment of areas of the body that are not painful and away from the painful site. This is sometimes necessary to correct a problem in a functionally related area that can be causing your pain. If you have any questions or concerns regarding your treatment please feel free to discuss them with your therapist.

Patient/Client/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### BENEFIT ASSIGNMENT/RELEASE OF INFORATION

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, HMO, PPO, workers compensation and third party payors for Industrial Hand and Physical Therapy, Inc.. A duplicate NCR copy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Client/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### FINANCIAL POLICY STATE

Industrial Hand and Physical Therapy, Inc. will bill my insurance carrier solely as a courtesy to me. I am responsible for the entire bill when the service(s) are rendered. I will make arrangements for payment of my estimated share today. If my insurance carrier does not remit payment within 60 days, the balance will be due in full from me and I will make all efforts to assist obtaining payment from my insurance carrier. In the event that my insurance company requests a refund of payment made, I will be responsible for the amount of money refunded to my insurance company. In the event my insurance company establishes an internal usual and customary fee schedule, I will be responsible for the difference remaining. If any payment is made directly to for services billed by Industrial Hand and Physical Therapy, Inc., I recognize an obligation to promptly remit same to Industrial Hand and Physical Therapy, Inc..

The above does not apply for those clients who are considered Worker's Compensation. However, I am advised if I claim worker's compensation benefits and am subsequently denied such benefits, I may be held responsible for the total amount of charges for services rendered to me.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collection monies owed, including court costs, collection agency fees and attorney fees. The above information has been read by me and any questions I had have been answered. I understand my responsibility for the payment of my account.

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Signature of Patient/Client/Guardian/Responsible Party

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Center Representative/Witness