SSM Health Physical Therapy
A service of SSM Health Rehabilitation Hospital

Consent to Treatment: Authorization to Release Information: and Statement of Financial Responsibility

Revised 08/01/2018

Patient Name:_____ **Date**:_____ **Acct#**:_____

SSM Health Physical Therapy appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payment at the time of service and for any deductible /coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. If your account is not paid in full and is referred to a collection agency, any fees incurred in collecting on your unpaid balance will be your responsibility. For your convenience, we accept cash, checks and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement. Payments can be made at the center, mailed to the address on your statement, or you may access our on-line bill payment option @ https://pay.instamed.com/SSMBILLPAY once a statement is received from the billing office, or by calling our customer service department at 1-866-889-9968.

I have read the above policy regarding my financial responsibility to SSM Health Physical Therapy for providing rehabilitative services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to SSM Health Physical Therapy. I agree to pay SSM Health Physical Therapy the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier. *Patient Service Specialist Initials:* _____

Signature:_____(relationship to patient: self – guardian – other**:**_____) **Date:**_____

You agree that in order for us to collect any amounts you may owe, we may contact you by any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and use of automatic dialing devices, as applicable.

Signature:_____(relationship to patient: self – guardian – other**:**_____) **Date:**_____

**Please note that the information included in this *Statement of Financial Responsibility* form is subject to any applicable state laws, rules or regulations that impact your financial responsibility and whether there is an amount owed.

You will receive calls and/or text messages that deliver autodialed or pre-recorded telemarketing messages from an automatic telephone dialing system. You consent to receive such calls and/or texts at the telephone number associated with your account. Your consent to receive such calls and/or text messages is not a condition of any purchase of a service or product.

I/We have read this disclosure and agree that Provider, and/or their representative, may contact me/us as described above.

Signature:_____(relationship to patient: self – guardian – other:_____) **Date:**_____

I acknowledge that the Notice of Privacy Practices and Notice for Federal Civil Rights is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

Signature:_____(relationship to patient: self - guardian - other:_____) **Date:**_____

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I am aware of my diagnosis and voluntarily consent to have SSM Health Physical Therapy, through its appropriate personnel, provide evaluation and/or treatment as prescribed by my physician and/or recommended by my therapist. I understand the practice of physical, speech, and occupational therapy is not an exact science, and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand that the treatment I receive from SSM Health Physical Therapy is limited to physical, speech, and/or occupational therapy services and that I shall seek treatment from other medical professionals for all other issues I may experience. I understand that I have the right to ask questions at any time during the course of my care.

Signature:_____(relationship to patient: self - guardian - other:_____**) Date:** _____

I further authorize SSM Health Physical Therapy to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

Signature:_____(relationship to patient: self - guardian - other:_____) **Date:**_____