PHYSICAL THERAPY
& WELLNESS CENTER

AUTHORIZATION FOR PAYMENT & CONSENT FOR TREATMENT

AUTHORIZATION FOR PAYMENT: I authorize payment to be made to RHC Physical Therapy and Wellness Center *(Rehabilitation Health Center)* by my insurance company or, in the case of litigation, my attorney, for all services provided to me. I request payment of authorized benefits be made on my behalf from:

- ☐ Title XVIII (Medicare)
- ☐ Blue Cross Blue Shield of ______________________
- ☐ HMO/PPO ______________________
- ☐ Worker's Compensation
- ☐ No-Fault Auto
- ☐ Attorney ______________________
- ☐ Other ______________________

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

While RHC Physical Therapy and Wellness Center will attempt to receive payment directly from my insurance company, I understand that I am ultimately responsible for payment of services provided to me or for the benefit of my spouse, child or ward by RHC Physical Therapy and Wellness Center. I understand that RHC Physical Therapy and Wellness Center will submit claims to my insurance company two times and if payment is not received the balance due becomes my responsibility. I understand that if I am billed for services rendered I will have 30 days to make payment or an $8.00 late fee will incur. Returned checks are subject to a $25.00 service charge.

I authorize RHC Physical Therapy and Wellness Center to speak with the following person/persons regarding payments or billing questions incurred during my Physical Therapy treatment.

______________________ Name

______________________ Name

Please be advised these are the only person/persons we will discuss your financial obligations with.

I certify that the foregoing has been fully explained to me and I understand the contents.

______________________ Patient Signature

______ /______ / ______ Date

______________________ Parent or Guardian

______________________ Witness

CONSENT FOR TREATMENT: I hereby authorize RHC Physical Therapy and Wellness Center, and its agents, to provide me with the care, treatment and procedures ordered by my referring physician and requested by me or my guardian. I certify that the extent and purpose of these services have been fully explained to me and/or my family.

______________________ Patient Signature

______ /______ / ______ Date

______________________ Therapist Signature

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