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Baton Rouge, La. 70810
Phone: 225-767-4440 Fax: 225-767-4441

30789 La. Highway 16, Suite D-2
Denham Springs, La. 70726
Phone: 225-664-9150 Fax: 225-664-9170

FINANCIAL RESPONSIBILITY - AUTHORIZATION, CANCELLATIONS AND ASSIGNMENTS

PATIENT NAME: _____ DATE: _____

FINANCIAL RESPONSIBILITY

This is to certify that the information provided to Dutch Physical Therapy, Inc. is true and correct to the best of my knowledge and belief. In consideration of the services rendered to the patient named above, I/we assume responsibility for and guarantee the payment of all Physical Therapy charges in accordance with the practice's then current rate. Total charges are payable when rendered. The legal interest rate of 8.5% will be added to all unpaid patient accounts over 30 days old. I/We authorize Dutch Physical Therapy to charge patient balances over 90 days old to my/our credit card account that you have on file. I/we also agree that, except as provided by law, I/we shall be responsible for the payment of any Physical Therapy charges which, for any reason, are not paid by any payor or insurance company. In the event this account is rendered delinquent and requires legal action to resolve payment, I/we agree to pay, in addition to the principal due, a fee of forty percent (40%) of the total bill added to the amount due on the account and twenty dollars (\$ 25.00) on NSF checks to cover the collection agency and/or attorney fees and expenses incurred by this facility.

*******NON-CANCELLATION NOTICE AND FEE*******

I/we agree to cancel my appointment within twenty-four hours of the scheduled appointment time. If I do not comply, I/we agree to be assessed a \$25.00 office fee payable by me, not payable by my insurance company, before any more services are rendered.

CONSENT FOR TREATMENT

I/we agree and consent to all procedures and medical treatments deemed necessary by the patient's physical therapist. I/we acknowledge that there is no guarantee, expressed or implied, as result of procedures and medical treatment performed.

MEDICAL RELEASE AND ASSIGNMENT OF INSURANCE BENEFITS

I/we authorize Dutch Physical Therapy, Inc. To release any and all medical records and/or billing information to the Social Security Administration, health maintenance organizations, workmen compensation carriers, employers, or persons acting on behalf of a preferred provider arrangement (or any of their agents or representatives), when such information is requested for payment, utilization review or coverage determination purposes. I/we understand that I/we may revoke this consent at any time, except in instances where a particular action depends upon the consent remaining in effect, including, but not limited to securing full payment of the account(s). This authorization shall remain in effect for a period of not more than two years from the date shown below or until payment of this account is rendered in full, which ever is greater. I/we further authorize any such payor or insurance company to pay directly Dutch Physical Therapy, Inc. all benefits due and payable as result of services rendered by Dutch Physical Therapy, Inc. I/we hereby assign to any physical therapist providing manual and physical therapy, or other services rendered in connection with this treatment, all benefits due me for such services under any applicable policy of insurance. I/we accept the financial responsibility to said Physical Therapist for all charges and services not paid by any payor or my insurance company and hereby promise to pay within thirty (30) days of the date rendered any remaining balance. The authorization to release medical information herein contained shall also apply to the Physical Therapists referred to in this paragraph.

PATIENT'S SIGNATURE (If unable to sign, then
Legal Guardian or Next of Kin)

DATE

WITNESS

RELATIONSHIP TO PATIENT