INTEGRATED PHYSICAL THERAPY, INC.
20815 N 25th PL Suite 100
Phoenix, AZ 85050 Phone (602) 374-2760 Fax (602)354-8184

CONSENT FOR EVALUATION, CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent to Integrated Physical Therapy, Inc. to furnish physical therapy evaluation, care and treatment to _____ considered necessary and proper in assisting the physician to diagnosis or treat my/his/her physical and/or mental condition. This may include: modalities of hot/cold pack, mechanical/manual cervical/pelvic traction, electrical muscle stimulation, vasopneumatic device, paraffin bath, iontoporesis with dexamethazone, ultrasound with/without electrical stimulation/hydrocortisone crème, therapeutic exercises, neuromuscular re-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, work hardening/conditioning, prosthetic training, wheelchair management/propulsion training, development of cognitive skills, transcutaneous electrical nerve stimulation, procedure of would care, dressing changes, acupressure over trigger point, strain/counter strain, 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 painful and away from the painful site. This is something necessary to correct a problem in a functionally related area that can be causing your pain. If you have any questions or concerns regarding treatment, please feel free to discuss then with your therapists.

PATIENT/GUARDIAN SIGNATURE:_____DATE:_____

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, HMO, PPO, worker's compensation and third party payors for Integrated Physical Therapy, Inc.. A duplicate NCR copy of this agreement 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/GUARDIAN SIGNATURE:_____DATE:_____

FINANCIAL POLICY STATEMENT

Integrated 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 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 my insurance company establishes an internal usual and customary fee schedule, I will be responsible for the difference remaining. If any payment is made to me directly for services billed by Integrated Physical Therapy, Inc, I recognize an obligation to promptly remit the same to Integrated Physical Therapy, Inc.

The above does not apply for those clients care is considered by 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 payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting 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.

_____DATE:_____
SIGNATURE OF PATIENT/GUARDIAN/RESPONSIBLE PARTY

_____DATE:_____
INTEGRATED PHYSICAL THERAPY, INC. / WITNESS