SOUTHERN LAKES PHYSICAL THERAPY

2121 South Kinnickinnic Ave
Suite Three
Milwaukee, WI 53207
414-744-0707

CONSENT TO PHYSICAL THERAPY

I, the undersigned, do hereby agree and give my consent for Southern Lakes Physical Therapy, S.C. (SLPT) to furnish medical care and treatment to, _____ (please print your name), considered necessary and proper in diagnosing or treating his / her condition.

I, hereby assign all medical and / or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to SLPT.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM. ANY QUESTIONS I MAY HAVE HAD HAVE BEEN ANSWERED TO MY SATISFACTION

Signature: _____ Date: _____

BILLING POLICY, RELEASE, AND AUTHORIZATION

I authorize (SLPT) to bill my insurance company directly for the covered portion of charges and I authorize payment of medical benefits directly to SLPT. I authorize SLPT to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges and agree to pay my deductible, my co-insurance or co-payment and any charges not reimbursed by my insurance carrier. I understand that some insurance companies require medical or administrative pre-authorization for treatment or have reimbursement limits on physical therapy treatment. I understand I am responsible for knowing and meeting the requirements of my insurance plan.

Signature: _____ Date: _____

FINANCIAL POLICY STATEMENT

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 collecting monies owed, including court costs and attorney fees.
Check: If I make a payment by check, and the check is dishonored or returned for any reason, I understand that SLPT will expect payment in full including the returned check fee within 30 days of the returned check.
Worker's Compensation: If you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.
Legal Cases: If any payment is made directly to me for services billed by SLPT, I recognize my obligation to promptly remit the same amount to SLPT.
Health Insurance: If any payment is made directly to me for services billed by SLPT, I recognize my obligation to promptly remit the same amount to SLPT.
In-Network: Staff at SLPT will do their best to verify your insurance information as a courtesy to you. However, it is not a guarantee of payment. Benefits are determined at the time the claim is processed. Co-pays will be collected at the time services are rendered. Your co-pay for physical therapy is $_____ per visit. When payment from your insurance company is received by SLPT, we will know then if your co-pay needs to be modified. If you have a co-insurance or a deductible, a bill will be sent to you for prompt payment.
Out of Network: Your responsibility is $_____ each visit.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE FINANCIAL POLICY STATEMENT

Signature: _____ Date: _____