# Lago Vista Physical Therapy

## *Assignment of Benefits/Acknowledgment of Co-pay*

I, the undersigned, do hereby authorize and demand the assignment of all medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance and any other health plans to Lago Vista Physical Therapy.

I hereby authorize Lago Vista Physical Therapy to release all information necessary to secure the payment of said benefits. I understand that the benefits represented to me today are not a guarantee of payment by any insurance company. I acknowledge I am ultimately responsible for all charges and any balance remaining after insurance has paid. I hereby authorize Lago Vista Physical Therapy to disclose or obtain all or any part of my or my dependent's records to or from any person or corporation which may be liable for all or any part of the charges of Lago Vista Physical Therapy including, but not limited to, insurance companies, worker's compensation carriers, or employers.

## *Patient Responsibility*

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied for payment. In certain circumstances the, insurance company may send a check for the services provided by Lago Vista Physical Therapy directly to the patient. In such cases, the patient agrees to endorse and send such a check to Lago Vista Physical Therapy. If the patient deposits such a check into a personal account, the patient agrees to send Lago Vista Physical Therapy a check for the equivalent amount.

If the patient receives from an insurance company, Medicare or Medicaid, and Explanation of Benefits (EOB), the patient agrees to send a copy of the EOB, by US Mail:

Lago Vista Physical Therapy

P.O. Box 4649

Lago Vista, TX 78645

## *Informed Consent for Treatment*

I have been informed of the expected benefits and/or goals of care. Reasonable alternatives of recommended treatment have been explained to me and my questions concerning any care have been answered to my satisfaction.

I understand that there are potential risks involved in the treatment I will be receiving through Lago Vista Physical Therapy. I understand that I have the right to refuse or to terminate my care at any time throughout the course of treatment. I consent to the recommended course of treatment.

## *Authorization for Release of Medical Information*

I hereby authorize Lago Vista Physical Therapy to release medical information in connection with these services of health insurance purposes or to the patient's physician or to the employer of the event of a workers Compensation injury. I also authorize the release of medical information from my physician, clinic hospital, in connection with my past or present condition.

Patient/Legal Guardian Signature_____ Date_____