CONFIDENTIALITY & CONSENT

Consent for Care & Policy Disclosure: I do hereby give my consent for Therapy Solutions to perform any therapeutic procedure or treatment considered in the evaluation and treatment as described to me or as my physician or therapist determines are necessary and consistent with my diagnosis. I understand I have an opportunity to ask questions regarding my treatment and that my therapist will be available to answer any questions. I understand I may terminate any treatment at any time.

Assignment of Benefits (Health Insurance)/Release of Information: I hereby assign all medical benefits to which I am entitled, to include any major medical, private insurance and third party payers to Therapy Solutions. A photocopy of this assignment is to be considered as valid as the original. I am responsible for understanding my insurance coverage. I hereby authorize Therapy Solutions to release all information necessary, including medical records to secure payment. I understand that I am financially responsible for all charges not covered by my insurance or other third party payers and that the balance after insurance or third party payment has been made is due within thirty (30) days. *(See Patient Financial Responsibility Policy)*
I agree to contact my insurance carrier to find out if my treatment is covered and to take such steps as requited to qualify my treatment for coverage. I agree to inform Therapy Solutions of any changes in my insurance.

I authorize payment directly to Therapy Solutions for services rendered.

Payment Guarantee: As a courtesy, Therapy Solutions, verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.
It is the policy of Therapy Solutions that payment is due at the time of service unless other financial arrangements are made in advance. At the conclusion of your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.
Please remember you are responsible for all charges incurred; your physician's referral and our verification of your insurance benefits are not a guarantee of payment.
We highly recommend you also contact your insurance carrier and check into your coverage. *(See Patient Financial Responsibility Policy)*

Notice of Privacy Practices: I acknowledge that I have read through the ***Notice of Privacy Practices*** from Therapy Solutions. I understand that my protected health information may be used as described in the notice. I have been notified I have the right to request a copy of the *Notice of Privacy Practices.*

Patient's Signature **Date**

Patient Name (Print) **DOB**

Guardian/Power of Attorney (If minor or adult unable to sign) **Date**