Owoc Physical Therapy & Associates, LLC
OwocPhysicalTherapy.com
20 Commerce Park N. / Ste. 103
Bedford, NH 03110
603.472.5546 tel.
603.472.5095 fax

Consent Form

_____
Patient's Name (please print)

Physical Therapy Treatment Consent:

Signing below, I authorize treatment of Physical Therapy services provided by Owoc Physical Therapy & Associates, LLC for myself or my dependent.

_____ _____ / _____ / _____
Signature (Patient / Guardian) Authorizing Sevices Date

Physical Therapy Payment Agreement: (select only one)

☐ **Direct Insurance Billing Payment Agreement:** (checked when Owoc PT & Assoicates, LLC is a participating provider aka in network provider, required by law, or agreed to take assignment)

I request that payment of authorized Primary Health Insurance benefits be made on my behalf to Owoc Physical Therapy & Associates, LLC for any services furnished to me or my dependent. I authorize holder of medical information about me or my dependent to release to any third party payer, and their agents any information needed to determine these benefits or the benefits payable for related services.

I understand that my or my dependents medical insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents unless Owoc Physical Therapy & Associates, LLC has contractual agreements for assignment that release me from this responsibility. I agree to pay at the time of service for: treatment that is not authorized by my insurance carrier, all co-pays, co-insurance, and deductibles for treatment. I agree to pay for any treatment that is denied by my insurance carrier.

☐ **Non Participating Provider and Out Of Network Payment Agreement:** (checked when Owoc PT & Associates is a non participating provider, out of network provider, or has no contractual relationship with the clients third party payer, including all Workers Compensation and Motor Vehicle Insurance)
I agree to be responsible for payment at the time of service for all services rendered on my or my dependents behalf. I am requesting coding for insurance billing with charge structure associated so that I may be able to submit these charges to a third party payer for reimbursement determination. I agree to be responsible for obtaining any referral, order, or authorization if any is required. Owoc Physical Therapy & Associates, LLC will provide me with an invoice containing: date of each service, place of each service, description of each service or supply, charge for each service, therapist name address and NPI numbers associated with the services provided, and diagnosis being addressed in treatment. Documentation of the services provided will be available once completed. I understand that this coding does not guarantee reimbursement by a third party payer.

☐ **Medicare Payment Agreement:**

I understand that Owoc Physical Therapy is a non-participating provider for Medicare. Owoc PT will send billing to Medicare not taking assignment. Medicare and the supplemental plan if any will pay the patient. The patient will be responsible to pay Owoc PT the patient responsibility amount as determined by the Medicare. I understand Owoc PT may request payment at the time of service for all services rendered on my or my dependents behalf. I understand Owoc PT is permitted and may determine on a case by case basis to send an invoice requesting payment after receiving the remittance notice from Medicare. In understand and agree payment is due in full on receipt of an invoice.

_____ _____ / _____ / _____
Signature (Patient / Guardian) Authorizing Payment (checked above) Date

Release of Medical Information Consent: (check box to authorize release of medical information)

☐ In order to ensure proper follow-up and continuity of care, I agree that a copy of my or my dependents medical information and transmission of information concerning my or my dependents care may be released by Owoc Physical Therapy & Associates, LLC to my Primary Care Physician and Referring Physician (if any)

_____ _____ / _____ / _____
Signature (Patient / Guardian) Authorizing Release Medical Information Date

☐ (if checked) Owoc Physical Therapy & Associates LLC has agreed to not require payment of services at the time of service and will send invoicing once Medicare remittance is received indicating patient responsibility. As above patient agrees payment is due on receipt of the invoice.

_____ _____ / _____ / _____
Provider Signature Date