

WILDERMAN AND ASSOCIATES PHYSICAL THERAPY CONSENT

_____ **Consent to Treatment:** I consent to rehabilitation and related services at Wilderman and Associates Physical Therapy, P.C. I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.

_____ **Treatment of Minors:** I, as parent/guardian of a minor receiving rehabilitation and related services at Wilderman and Associates Physical Therapy, P.C., do hereby agree and understand that I have been advised that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature and that I have been further advised to remain in the facility during any such treatment. I waive any claim I may have resulting from my failure to do so.

_____ **Liability:** I acknowledge and agree that Wilderman and Associates Physical Therapy, P.C. is not responsible for loss or damage to personal valuables that I brought onto the Wilderman and Associates Physical Therapy, P.C. premises.

_____ **Authorization of Payment:** I hereby authorize Wilderman and Associates Physical Therapy, PC to furnish information to insurance carriers concerning my illness and treatment. I hereby assign to Wilderman and Associates Physical Therapy, PC all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by the insurance. All professional services rendered are charged to the patient. Payments may be arranged. Failure to make payment when requested and/or per agreement is basis for legal action and the undersigned agrees to pay all costs associated with the collection. I acknowledge receipt of this financial policy and understand its contents. If account is referred for collections the debtor is responsible for all fees associated with collection of the account

_____ **Responsibility for Non-covered Services:** Wilderman and Associates Physical Therapy, PC and/or referring physician may determine that there are certain routine services or supplies that are necessary for the maintenance of good health and standard medical care that are not covered by Medicare contract or other insurance contracts. I/we acknowledge, understand and agree to be fully responsible for any and all amounts charged by Wilderman and Associates Physical Therapy, PC for such non-covered services. Example of non-covered service: orthopedic supplies and splints.

_____ **I acknowledge receipt of Notice of Privacy Practices.**

_____ **Returned Check Fee:** There is a \$25 fee for all returned checks.

Signature of Patient/Parent/Guardian _____ Date _____