

Oasis Therapy

Consent and Statement of Financial Responsibility

- 1. CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.
- 2. APPOINTMENT ATTENDANCE AGREEMENT:** I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times give one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of \$50 or \$75 depending on appointment type.

_____x

WORKER'S COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

- 3. RESPONSIBILITY FOR PAYMENT:** All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Oasis Therapy, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Oasis Therapy with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible.

Please note that refusal to sign this form does not change responsibility for payment in any way.

- 4. ASSIGNMENT OF BENEFITS:** I hereby assign to Oasis Therapy all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

5. CONSENT FOR EMERGENCY CONTACT INFORMATION

Person to contact in case of an emergency:

Name

Telephone Number

Relationship:

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

Signature of Patient or Legally Responsible Person

Date

Printed Name of above

Date