AVALON REHAB OFFICE POLICIES

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize **Avalon Rehab** to treat the minor patient named in the attached forms while I am not present.

CONSENT FOR CARE AND TREATMENT: Your physical therapist will complete an evaluation by examination and interview. Your Individual treatment program will then be designed. A variety of treatment techniques may be used. I, the undersigned, do hereby agree and give my consent for **Avalon Rehab** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

ASSIGNMENT FOR INSURANCE BENEFITS: I hereby authorize **Avalon Rehab** to furnish information to insurance carriers concerning this treatment, and I hereby assign all payments for services rendered.

WORKERS' COMPENSATION CLAIMS: If you claim Workers' Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered.

CANCELLATION AND NO-SHOW POLICY: We require 24 hours notice in the event of a cancellation. The charge for cancellation, without proper motive, is $25 for a physical therapy visit. This charge will not be recovered by insurance, but will have to be paid by you prior to receiving further treatment.

X _____

Signature - Patient / Guardian / Responsible Party Date

FINANCIAL POLICY: Avalon Rehab bills your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. We require that arrangements for payment of your estimated share be paid today. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you from the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to **Avalon Rehab**. If formal collections procedures become necessary, you will be responsible for any additional costs that occur. Your Insurance benefits as quoted to us by your Insurance carrier have been reviewed with you. We assume no liability for any errors made by your Insurance carrier in this quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

The above Financial information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT WITH **AVALON REHAB**.

X _____

Signature - Patient / Guardian / Responsible Party Date

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Signature – Clinic Representative Date