PATIENT AUTHORIZATION

Release of Information

All information provided herein is true and correct. I hereby consent to treatment.

I give permission to Physical Therapy Care & Aquatic Rehab of Fort Bend and its subsidiaries and affiliates to release information, verbal and written contained in my medical record and other related information, to my insurance, rehab nurse, case manager, attorney, employer school, related healthcare provider, assignees and/or healthcare beneficiaries and all other related persons to my treatment.

I authorize Physical Therapy Care & Aquatic Rehab of Fort Bend and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment. Information without patient identifiers may be used for quality assurance purpose.
I have read and understand the above release.

Patient/Guardian Signature: _____ Date: _____

Assignment of Benefits

I authorize payment directly to Physical Therapy Care & Aquatic Rehab of Fort Bend, its subsidiaries and/or affiliates for service. This direct assignment shall be considered as effective and valid as original.

Patient/Guardian Signature: _____ Date: _____

Payment Guarantee

I agree to pay Physical Therapy Care & Aquatic Rehab of Fort Bend, its subsidiaries and/or its affiliates for the services provided to me or the party named above. If any law such as worker's compensation or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, release or any other type of information necessary to allow for the speedy collection form my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances. The benefit verification form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance is not accurate or the insurance company changes its coverage, I will be responsible for payment of services.

I further understand that this agreement is binding regarding of any legal transaction currently in progress for initiated during or after the course of my treatment unless agreed to in writing by myself and a representative of Physical Therapy Care & Aquatic Rehab of Fort Bend, and or its affiliates or subsidiaries.

Patient/Guardian Signature: _____ Date: _____

Late Cancellation/Missed Appointment/No Show Policy: Effective 9/1/2015

With respect and value to our therapist's time and in consideration of our other patients, Physical Therapy Care & Aquatic Rehab of Fort Bend requires advanced notification of appointment changes.

Cancellation or rescheduling of appointments is expected at least 24 hours prior to the scheduled appointment time by calling the attending Clinic Richmond office at 281-344-8900 or Katy/Fulshear Office at 281-347-8900.

If I fail to notify PT Care less than 24 hours in advance of scheduled appointment, I will be assessed a fee of $25 before being seen on my next scheduled appointment. The "Late /Cancellation" fee is NOT covered by insurance.

Patient/Guardian Signature: _____ Date: _____