Buffalo Grove Physical Therapy & Sports Rehabilitation, P.C.
125 E Lake Cook Rd, Suite 209
Buffalo Grove, IL 60089

Phone: (847) 520-3382 | **Fax:** (847) 520-3404 | **info@bgpt.net**

CONSENT TO TREATMENT AND PAYMENT

CONSENT TO MEDICAL TREATMENT

The undersigned hereby consents to all evaluation, diagnostic and treatment procedures provided by **BUFFALO GROVE PHYSICAL THERAPY & SPORTS REHABILITATION, P.C.** (*"BGPT"*) as deemed necessary or advisable by the undersigned's treating physician and related medical personnel who may be employees or other agents of BGPT. The undersigned acknowledges that no guarantee has been provided by BGPT as to the results of any care and/or treatment which may be provided.

INSURANCE AUTHORIZATION

The undersigned authorizes payment to be made directly to BGPT from all insurance carriers for services provided on my behalf. The undersigned agrees that he or she is financially responsible to BGPT for any deductibles, co-insurance, co-payment and/or services not covered by their insurance carrier. The undersigned further authorizes BGPT to release any information required for the processing of insurance/payor claims and the receipt of payment to BGPT. The undersigned agrees to notify BGPT immediately in the event of a change in insurance carrier/payor.

PARTICIPATING INSURANCE CARRIERS/MANAGED CARE

Co-payments and/or services not covered by the undersigned's insurance carrier are due at the time services are rendered. Co-insurance and deductible payments are due upon receipt of your insurance carrier's EOB (Explanation of Benefits). Deductible and the co-insurance payments are the undersigned's responsibility and shall be paid within fifteen (15) days after receipt of BGPT's request for payment, unless the undersigned and BGPT have agreed upon and signed a specific alternate payment plan.

NON-PARTICIPATING PLANS

For patients covered under non-participating plans, all charges are due in full at the time services are rendered. We do not submit bills to carriers that we are not contracted with, but will provide patients with the necessary information for them to file claims directly to their insurance carrier.

UNPAID CLAIMS THAT HAVE BEEN BILLED TO THE INSURANCE COMPANY

We do not "re-bill" insurance carriers after ninety (90) days from the initial visit for services deemed to be covered by the undersigned's insurance carrier/payor. Any balances that have not been paid by the insurance carrier/payor within ninety (90) days from the initial visit shall be paid by the undersigned.

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CONSENT TO TREATMENT AND PAYMENT (continued)

SELF-PAY/UNINSURED

Payment is due at the time services are rendered for all self-pay and/or uninsured patients.

COLLECTIONS

Any fees not paid in accordance with BGPT policies will be forwarded to collections. The undersigned is responsible for all costs related to obtaining payment, including, but not limited to, collection agency fees, court costs and legal fees.

MISSED APPOINTMENTS/NON-SUFFICIENT FUNDS CHECKS

BGPT reserves the right to charge the undersigned S25.00 for cancelling an appointment with less than 24-hour notice. A fee will be charged for all returned checks in accordance with applicable bank charges. Neither fee will be submitted to any insurance carrier/payor.

RELEASE OF MEDICAL RECORDS AND PREPARATION OF MEDICAL FORMS

A written request is required for the release of all medical records. While BGPT will make every effort to respond to record requests within a reasonable time, please allow up to thirty (30) days to receive records. There will be a copying and postage fee for all medical record requests.

I fully consent to receive treatment and services from BGPT. I understand that I'm responsible for complying with all policies and fees set forth herein. Further, I understand that BGPT reserves the right to change any fees and/or policies without prior notification. I have been given the opportunity to ask any questions I may have regarding my consent to treatment and my responsibilities for payment.

Please note that any and all equipment within BGPT may only be used under the supervision of a licensed clinician.

_____ _____

Signature of Patient or Legal Guardian

Signature of Guarantor (if different from Patient or Legal Guardian)

_____ _____

Patient's Name

Date

_____ _____

Witness

Date