

Consent and Conditions of Admission

As either the patient or the legally authorized representative of the patient, the following consents, understanding, and agreements are made on my own behalf or on behalf of the patient in partial consideration of the health care services to be provided to the patient in the facility.

1. **Consent of Services:** On behalf of the patient, consent is hereby give to the facility, its medical staff, and employees to provide facility and other health care services to patient and to administer physician orders for the benefit of the patient. It is understood that there is a risk of substantial and serious harm involved in such facility and health care services, and such risk is accepted in the hope of obtaining beneficial results from such services. It is understood that Physical Therapists are separately responsible to explain what they do and in some cases, to obtain separate consent for some of the services they perform. It is understood that now and in the future, the patient's condition and the health care services; all such questions, if any, have been satisfactorily answered. No promises of any particular outcome or successful result have been made, it being understood and accepted that there is some uncertainty involved in the facility and health care services for which this consent is given.
2. **Miscellaneous agreements and understandings:**
 - A. **Medical Education.** Permission is given for observers involved in medical training and education to be present when the patient received health care services.
 - B. **Personal Property.** It is understood that the facility is not responsible for personal property.
 - C. **Release of information.** The law requires Physical Therapy & Sports Medicine at Kimball Junction to make and keep records of your medical treatment. Physical Therapy & Sports Medicine at Kimball Junction safeguards those records. Access to medical records is limited to persons who are providing, coordinating, evaluating, or improving health care, subject to applicable law. By receiving services at Physical Therapy & Sports Medicine at Kimball Junction and its employees, you agree to the release of medical records information for the use specified above, and for release to insurance companies or other third parties to assist in paying your health care costs.
 - D. **Assignment of benefits.** Any and all benefits from insurance companies and other companies and other third party payers that are payable to patient or on behalf of patient for health care services and related payment for services rendered or provided to patient are hereby transferred and assigned to facility for the exclusive purpose of paying for charges associated with health care services provided to patient in the facility. It is understood and intended that all insurance companies and other third party payers will pay benefits directly to facility in payment of facility's charges and the charges of any other health care providers for whom facility is authorized to bill in connection with health care services provided to patient.
 - E. **Financial responsibility.** Patient and the undersigned, if other than the patient, each jointly and severally agree to pay for all the health care services rendered to patient in the facility including but not limited to any amounts not paid by any insurance company or other third party payer. Patient and the undersigned, if other than the patient, remains responsible for all co-payments, deductible, co-insurance and/or non-covered services regardless of amount paid by insurance of third party payer. It is understood and agreed that charges not paid in a timely fashion may be placed for collection or with an attorney for purposes of collection. It is further understood and agreed by the patient and the undersigned that any amounts not paid within 30 days of the date of the facility's bill or statement for payment shall accrue interest at the rate of 1 ½% per month (18% per year) on the unpaid balance. In the event that any unpaid balance is placed for collection or with an attorney for collection, patient and the undersigned, if other than the patient, each jointly and severally agree to pay costs and a reasonable attorney's fee in connection with the collection process. A service charge of \$15.00 may be collected in connection with any check or other instrument rendered by me but returned unpaid to the facility.
 - F. **Medicare/Medicaid patient's certification.** I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers or the State any information needed to process a claim for this or any related service. I request that payment of authorized charges be made in my behalf directly to the facility for its charge and for any charges of Physical Therapists or other providers for whom the facility is authorized to bill in connection with its service.
 - G. **CHAMPUS/CHAMPV A Authorization.** I request payment of authorized benefits to the facility on my behalf for any services furnished me by the above named facility. I authorize any holder of medical or other information about me to release to undersigned signs this document either as the patient or as the agent representative of the patient authorized to execute this document and to accept and agree to its terms on behalf of the patient. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I understand what I am agreeing to by signing below. I understand that I am entitled to request and obtain a copy of this document.

Patient Signature: _____ Date Signed: _____

Patient's agent or representative _____ Relationship to patient: _____

Witness: _____