Mt. Dora
Physical Therapy
SPECIALISTS

PATIENT INFORMATION / CONSENT TO TREAT

Patient Name_____ Date of Birth _____ Age _____ Sex: M or F

Mailing Address_____City_____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer_____ Occupation _____ Retired _____

Referring Physician_____ Primary Physician_____ Date of Injury _____Date of Surgery_____

Contact In Case of Emergency_____ Phone Number _____Relationship_____

****IF PATIENT IS A MINOR PLEASE PROVIDE US WITH THE FOLLOWING INFORMATION**:

Parent/Guardian Name_____

Parent/Guardian Employer_____ Work Phone _____

NOTICE OF FINANCIAL RESPONSIBILITY

Insurance Company _____ **ID Number** _____

___I am receiving Home Health Care Services

Secondary Insurance _____ ___I am NOT receiving Home Health Care Services

*I will advise Mount Dora Physical Therapy Specialists, Inc. of any change in the above information

****PLEASE INITIAL THE FOLLOWING:**

_____ **I hereby authorize Mount Dora Physical Therapy Specialists Inc. to provide treatment as prescribed by my Physician, and understand that I am legally responsible for payment of all services rendered therein. As a courtesy, Mount Dora Physical Therapy Specialists, Inc. agrees to bill the above Insurance Company on my behalf and assist in obtaining information regarding coverage limits/authorizations/referrals, etc. However, I fully understand it is ultimately my responsibility to know my insurance plan and the coverage provided.**

_____ **I hereby assign all insurance benefits for services rendered to be paid directly to Mount Dora Physical Therapy Specialists, Inc. Should my insurance carrier ever deny payment for treatment received, or retract payment on services rendered, I personally will reimburse Mount Dora Physical Therapy Specialists, Inc. for such services. Additionally, I understand that I am financially responsible for any collection/attorney fees that may be assessed to my account due to non-payment of these charges. Mount Dora Physical Therapy Specialists, Inc. will do its best to accommodate you, the patient, by entering into a re-payment agreement if necessary.**

_____ **I am responsible for paying any deductible or co-insurance amounts. I understand that co-payments are due at the time of services.**

SIGNATURE OF PATIENT_____**DATE**_____