Mercy Integrated Physical Therapy
Centura Health®

Patient Registration and Consent for Medical Treatment

1. **Consent for Health Care Services**: I authorize consent for medical treatment at Mercy Integrated Physical Therapy.
2. **Authorization for Release or Information**: Mercy Integrated Physical Therapy and my Physical Therapist may release information from my medical records to any health care provider involved in my care and treatment. Mercy Integrated Physical Therapy and my Physical Therapist may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare/Medicaid programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Mercy Integrated Physical Therapy is no longer responsible for the confidentiality of any information know or possessed by the payer.
3. **Financial Agreement**: I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Mercy Integrated Physical Therapy and my Physical Therapist, which are not paid by my health insurance or other payer. **I understand that it is my responsibility to call my Insurance and to know and understand my Insurance policy and benefits. As a courtesy Mercy Integrated Physical Therapy will call for your benefits as well. Mercy Integrated Physical Therapy cannot be responsible for any misinformation given to us by your Insurance representative.** All charges are due and payable when I receive the bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Mercy Integrated Physical Therapy.
4. **Preauthorization Requirements**: I accept the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Integrated Physical Therapy charges.
5. **Assignment for Direct Payment**: I authorize that payment of any insurance (including auto insurance or health-care insurance) benefits for healthcare services or goods may be made directly to Mercy Integrated Physical Therapy, and my Physical Therapist, for charges not paid.
6. **Patient Cancellation and No-Show Policy.** If you miss or cancel three or more appointments, you will be placed on our Same Day Appointment schedule. If you are a Work Comp patient, our staff will inform your Human Resource Department and/or physician of any missed or cancelled appointments.
7. **Self Pay Patients.** I understand that if I choose to be a Self Pay Patient, I must pay at the time of my visit in order to receive my 30% discount.

I acknowledge that:

1. I have read this form and understand its contents.
2. I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.
3. I am responsible for the payment and/or co-payment that is due at the time of service.

_____ _____
Signature of patient or legally responsible person Name (PRINT)

_____ _____
Relationship/ reason why patient is unable to sign Date