



## CONSENT TO TREAT AND CONDITIONS OF ADMISSION

**1 CONSENT TO REHABILITATION PROCEDURES:** The undersigned consents to the procedures which may be performed during this and future out patient physical therapy visits that are performed at Proaxis Therapy.

**2 LEGAL RELATIONSHIP BETWEEN PROAXIS THERAPY PHYSICAL THERAPISTS:** All Physical Therapists, and Physical Therapist assistants are employed by Proaxis Therapy, LLC.

**3 RELEASE OF INFORMATION:** Upon inquiry and to the extent allowed by law, Proaxis Therapy may make available certain basic information about the patient in accordance with HIPPA regulations, including name, address, age, sex, general description of the reason for treatment (whether an injury, burn, poisoning or other condition) general nature of the injury, burn, poisoning or other condition, and general condition. If the patient's representative does not want such information to be released, he/she must make a written request for said information to be withheld. The patient or his/her representative may present a written request to Proaxis Therapy for this purpose. The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, Proaxis Therapy may disclose portions of the patients record including his/her medical record, to any person or entity which is or may be liable for all or any portion of Proaxis Therapy's charges, including but not limited to government agencies (e.g., Medicare, Medicaid, insurance companies, health care service plans, or workers compensation carriers). By signing below, I acknowledge that I have received Proaxis Therapy's Notice of Privacy Practices.

**4 FINANCIAL AGREEMENT:** The undersigned agrees whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of Proaxis Therapy in accordance with the regular rates and terms of Proaxis Therapy. All accounts are handled by an independent billing company, including billing, collections and all other matters relating to the account.

**5 ASSIGNMENT OF INSURANCE BENEFITS:** The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Proaxis Therapy of any insurance or other applicable (e.g., Medicare, Medicaid) benefits otherwise payable to or on behalf of the undersigned or patient for these outpatient services, at rate not to exceed Proaxis Therapy's regular charges. It is agreed that payment to Proaxis Therapy, pursuant to the authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. **Any pre-certification of insurance benefits is the patients sole responsibility.** The undersigned authorizes payment of Medicare/Medicaid benefits to be made on behalf of the patient for all services furnished by Proaxis Therapy. It is further understood by the undersigned that he/she is financially responsible for charges not collected by this agreement, unless otherwise stated by applicable written contract or law.

### **6 AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR PAYMENT:**

I hereby authorize the release of all information from the patients medical record that may be necessary to make reimbursement or payment for any or all the services rendered by the Therapist involved in my care with Proaxis Therapy. I hereby authorize my Insurer or any third party responsible for the payment of covered medical/surgical benefits on my behalf to make payment directly to Proaxis Therapy. As a patient I understand that I am responsible for my insurance benefits and understand my in network and out of network coverage.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patients legal representative, or is duly authorized by the patient as the patients general agent to execute this document and accept and agree to its terms.

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Patient / Guardian Signature

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Date

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Print Patient Full Name