FULL RANGE PT
& REHAB SERVICES
Your Life. Your Goals. Your Way.

Patient/POA Consent and Financial Responsibility

Full Range Physical Therapy, LLC has been asked by your physician or healthcare provider team to provide physical, occupational, and/or speech therapy evaluation and treatment services. Please read and discuss this document with your therapist, sign and date it to confirm your understanding of, and your agreement to, its content.

I. Informed Consent- My physician has prescribed, and Full Range Physical Therapy, LLC has designed a plan of care to provide physical therapy, speech language pathology, and/or occupational therapy to address one or more of my medical conditions. I agree to receive the services of Full Range Physical Therapy, LLC as recommended in the plan of care designed by my therapist and prescribed by my physician.

II. HIPAA Acknowledgement- I acknowledge receipt of the Notice of Privacy Practices for Full Range Physical Therapy, LLC and had the opportunity to review it with my therapist, prior to signing this document.

III. Statement of Financial Responsibility- I authorize direct payment to Full Range Physical Therapy, LLC from my primary insurance carrier and well as from my secondary and/or supplemental insurance carrier (if any), if my primary insurance does not cover my full bill. I will be billed for any uncovered portion, and I acknowledge my personal responsibility for that balance, to the extent permitted by law. Any uncovered portion may include primary and secondary insurance deductibles, copayments, coinsurances, and any other out of pocket expenses due to my insurance policies. I agree to forward any insurance payments that I receive from my insurance carriers directly to Full Range Physical Therapy, LLC. I am obligated to inform Full Range Physical Therapy, LLC of any changes in my insurance coverage.

Financial Services

Full Range Physical Therapy, LLC will make every attempt to obtain all proper insurance information for all admissions. It is recommended for our patients to contact their insurance companies to fully understand their covered benefits for rehabilitation services.

In the event that a patient's insurance benefit does not cover the full cost of the provided services, Full Range Physical Therapy, LLC is required to send balance bill to the patient or their assigned financially responsible party. If you require additional information or assistance, please contact Full Range Physical Therapy, LLC at 610-241-2685 or visit our website at www.FULLRANGEPT.org

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Services: ☐ **Physical Therapy** ☐ **Speech Therapy**
☐ **Occupational Therapy** ☐ **Other: _____**

Consent: By my signature below I acknowledge that I have read, understand and agree to the terms and conditions contained in the *Informed Consent* and the *Statement of Financial Responsibility* to release all information necessary to secure payment.

Signature: _____ Date: _____

Print: _____

Please check: ☐ **Patient** ☐ **Guardian**
☐ **Financially Responsible Party (Please Specify) _____**