FULL RANGE HEALTH SERVICES®
Your Life. Your Goals. Your Way.

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WWW.FULLRANGEHEALTH.ORG

Patient/POA Consent and Financial Responsibility

Please read and discuss this document with your therapist, sign, and date it to confirm your understanding of, and your agreement to its content.
Full Range Health Services, 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.

Informed Consent

My physician has prescribed, and Full Range Health Services, 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 Health Services, LLC as recommended in the plan of care designed by my therapist and prescribed by my physician.

Statement of Financial Responsibility

I authorize direct payment to Full Range Health Services, 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, co-payments, 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 Health Services, LLC. I am obligated to inform Full Range Health Services, LLC of any changes in my insurance coverage.

Open Home Healthcare Episode

I authorize that I am not engaged in services through a home health agency at this time. I further acknowledge that if I am engaged in services through a home health agency, the services provided by Full Range Health Services, LLC may be denied by my insurance company, in which case, the services will be billed directly.

Cancellation Policy

Please provide our team with 24- hour notice to change or cancel an appointment. Patients who do not maintain a scheduled appointment and do not provide 24-hour notice to change or cancel an appointment may be responsible for a $15.00 cancelled visit charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

Financial Services

Full Range Health Services, 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 Health Services, 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 Health Services, LLC at (P) 610-241-2685 or visit our website at www.FULLRANGEHEALTH.org

HIPAA Acknowledgment

I acknowledge receipt of the Notice of Privacy Practices for Full Range Health Services, LLC and had the opportunity to review it with my therapist, prior to signing this document.

Services: Physical Therapy_____ Occupational Therapy _____ Speech 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.

Print: _____ **Date:** _____

Signature: _____

Please Check: Patient:_____ Guardian:_____

Financially Responsible Party (Please Specify) _____