



Consent of Care and Treatment

I, the undersigned, do hereby agree and give my consent for *Rocky Mountain Spine and Sport Physical Therapy, LLC.* to provide medical care and treatment that is considered necessary and proper in diagnosing or treating my physical and mental condition.

Patient/Guardian: _____ Date: _____

Release of Information

I hereby authorize the said assignee to release all information necessary, including Medical Records, Physician notes, radiological scans, operation report(s), to provide care and secure payment for any treatment received at *Rocky Mountain Spine and Sport Physical Therapy, LLC.*

Patient/Guardian: _____ Date: _____

Financial Policy Statement

Rocky Mountain Spine and Sport Physical Therapy, LLC. will submit your claims to your insurance company, on your behalf. You are responsible for the entire bill once services are rendered. We may require that arrangements for payment of your estimated share be made prior to the rendering of services, depending on your insurance benefits. If your insurance does not remit payment within 60 days, the balance will be due from you. In the event that your insurance company establishes an internal usual and customary fee schedule, you will be responsible for the remaining difference.

If payment is made directly to you for services billed by us, you recognize that you now have the obligation to promptly remit payment to *Rocky Mountain Spine and Sport Physical Therapy, LLC.*

The above does not apply for those patients that are considered Worker's Compensation. However, be advised that if your WC claim is denied such benefits, you may be held responsible for the total amount of charges for the services rendered to you.

I understand and agree that if I fail to make payments for which I am responsible in a timely manner, I will be responsible for all cost of collecting monies owed, including court costs, collection agency and attorney fees, plus interest thereon at 18% (eighteen percent) per annum on all such amount outstanding. Also, please be aware that there will be a \$25.00 service charge on all returned checks and additional charges for the cost of collection.

Estimated Insurance Benefits:

Co-insurance*: _____ Co-payment: _____ Deductible: _____ Self Pay: _____

Note: Estimated benefits coverage is provided as a courtesy to you, but is not intended to release you from total responsibility for your account.

The above information has been read and explained to me. I understand my responsibility for the payment of my account.

Patient/Guardian: _____ Date: _____

Rocky Mountain Spine and Sport Physical Therapy, LLC Representative: _____