ATHENS PHYSICAL THERAPY
ATHENS NEURO AND BALANCE REHABILITATION
PHYSICIANS BACK AND NECK CLINIC
BETTER BONE CLINIC
CHRISTOPHER E. DOERR, D.O., P.C.

CONSENT FOR TREATMENT & FINANCIAL AGREEMENT

Patient Name: _____ Date of Birth: _____

1. ***Consent:*** By signing this form, I consent to treatment necessary or desirable for the patient named above**.** **I understand that if my insurance requires a referral from my Primary Care Physician, it is my responsibility to confirm that my referral is current and in effect before I arrive for my appointment.**

2. ***Covered Benefits:*** As a courtesy, we will verify and file your claim with your insurance carrier, however we cannot guarantee payment. You are responsible for payment of any deductible, co-payment/coinsurance, and any non-covered service as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. If your insurance company denies any part of your claim or if you or your physician elects to continue therapy past your allowed/approved visits, payment will be expected from you. Verification is only an explanation of benefits based upon information that we received from your insurance carrier. **IT IS NOT A GUARANTEE OF PAYMENT.** Please contact your insurance carrier directly to confirm your individual benefits for Physical Therapy services.

3. ***Co-payments:*** Co-payments and Co-insurance amounts must be paid at each visit according to your insurance contract. Please plan accordingly. We accept cash, checks and credit cards (Visa, Master Card, Discover, American Express and Care Credit).

4. ***Attendance Policy:*** Your therapist allocates a specific amount of time for your appointment in order to meet the needs of your rehabilitation program. We understand there are times when you must miss an appointment, but request that you give us **24-HOUR NOTICE**. We charge **$50.00 for Dr. Doerr and $25.00 for therapy cancellations when less than 24 hour notice as well as missed appointments.**

5. ***Returned checks:*** There is a fee of **$30.00** for each returned check.

6. ***Children:*** Unsupervised children are NOT allowed in the waiting area, rehabilitation areas or examination rooms.

7. ***Medication refills:*** Please allow 1-2 working days for prescription renewals. Refills may not be available on Fridays.

8. ***Completion of forms:*** There is a fee for special forms you may need us to complete. Please check with the staff regarding the charges.

I have read the above statements. It is my understanding that I am financially responsible to APT/ANBR/PBNC for the services provided to me or my dependent. I authorize my insurer to pay any benefits directly to APT/ANBR/PBNC. I agree to pay the full amount of all charges incurred by the above named patient that are not covered by my insurance carrier.

Patient or legal representative signature_____ Date _____

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MEDICAL RECORDS AND IMAGING RELEASE AUTHORIZATION

PATIENT NAME: _____

ADDRESS: _____

DATE OF BIRTH:_____

PLEASE RELEASE TO:

ATHENS PHYSICAL THERAPY/PHYSICIANS BACK AND NECK CLINIC / BETTER BONE CLINIC	**ATHENS PHYSICAL THERAPY**	**ATHENS NEURO AND BALANCE REHABILITATION**
195 MILES STREET	13231 JONES STREET	1088 BAXTER STREET, SUITE C
ATHENS, GA 30601	LAVONIA, GA 30553	ATHENS,GA 30606
PHONE: 706-546-1333	PHONE: 706-356-1333	PHONE: 706-549-7400
FAX: 706-546-5807	FAX: 706-356-1433	FAX: 706-549-7399

This form is used to request previous films (MRIs, X-rays, CTs, bone scans, etc.) lab work, diagnostic studies and medical records from previous providers.

I authorize PBNC/APT/ANBR to release any medical information to/from any physician or physician's office, laboratory, pharmacy, hospital or surgical facility involved in my care.

This authorization shall remain in force until revoked in writing by the patient or representative signing this form. If you wish to revoke authorization, please submit your request in writing and mail or hand deliver to one of the locations listed above.

PATIENT SIGNATURE: _____ DATE:_____

Athens Physical Therapy
Athens neuro and Balance Rehabilitation
Physicians Back and Neck Clinic
Better Bone Clinic
Christopher E. Doerr, D.O., P.C.

HIPAA AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize APT/ANBR/PBNC to disclose my protected health information to the following person(s):

Name	Relationship	Phone number

May we leave confidential clinical information on your answering machine? □ YES □ NO

I hereby authorize the release of all medical records on the patient listed above to the referring and family physicians, as well as all records necessary for the processing of insurance claims.

I have received and read the HIPAA privacy policy of Athens Physical Therapy/Athens Neuro and Balance Rehabilitation/ Better Bone Clinic and Physicians Back and Neck Clinic.

This release shall remain in force until revoked in writing by the patient or representative signing this form. If you wish to revoke authorization, please submit your request in writing and mail or hand deliver to 195 Miles Street. Athens GA 30601.

Patient or legal representative signature_____ Date _____