P·E·A·K
PHYSICAL THERAPY CENTER

Performance Enhancement & Kinetic Physical Therapy
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Consent to Treatment & Therapeutic Procedures

I, _____, hereby consent to the therapeutic procedures outlined below, to be performed by Cari McClemons and P.E.A.K. Physical Therapy. I agree to be evaluated and treated for Physical Therapy.

I understand that therapeutic procedures can include but are not limited to joint and soft tissue mobilization; clinic and home exercise programs; functional training including posture and body mechanics; modalities such as heat, ice, e-stim and ultrasound; and special procedures such as taping, neuromuscular e-stim.

I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time.

I understand that I may consult with other therapists and/or physicians at any time regarding my condition.

I understand that I may purchase exercise equipment from P.E.A.K. Physical Therapy or from any other source.

I authorize anyone associated with P.E.A.K. Physical Therapy to administer first aid to me, as they deem necessary for my well being.

I certify that I have read and understand the above consent statements:

Signature _____ Printed Name _____

Financial Responsibility Policy

I understand that P.E.A.K Physical Therapy is billing my insurance as a courtesy, and I hereby assign all physical therapy benefits directly to P.E.A.K. Physical Therapy. I understand that most insurance companies, (including Medicare), pay only a certain percentage of patient services depending on the policy. If they should deny my claim or any portion due, I understand that I am financially responsible and agree to pay for all charges related to services provided to me at P.E.A.K. Physical Therapy, regardless of the status of my insurance claim.

I agree to pay my account as SERVICES ARE PROVIDED. If for any reason there is a balance owing on my account, I will pay P.E.A.K. Physical Therapy promptly upon receipt of the statement. In exceptional circumstances, an extended payment plan may be arranged through our billing department. If so, these arrangements must be completed within ten (10) days of my initial visit to the office.

I request that payment of authorized Medicare benefits or other insurance benefits be made on behalf to P.E.A.K. Physical Therapy for any services furnished to me by P.E.A.K. Physical Therapy.

I understand my signature authorizes the release of my medical information to the insurance company. This information will only be disclosed to the insurance company once it has been requested and deemed necessary to determine if these benefits are payable to related services by the insurance company.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier. This authorization will remain valid until rescinded in writing.

I have read the above and fully understand the terms thereof.

Signature _____ Date _____