Consent for Care and Treatment

I give permission / authorization to Direct Access Therapy Inc., to furnish care and treatment to _____.

I assign all medical benefits to which I am entitled to Direct Access Therapy Inc. A photocopy of this assignment membership will be considered as valid as the original and I authorize the assignee to release the necessary information, including medical information to secure payment for services rendered.

I authorize Direct Access Therapy Inc. to forward the necessary information, including medical records, medical history, services and treatment rendered for the purposes of claims processing, financial audit, utilization review and for any other purpose reasonably related to the above activities. Your personal and medical information will not be given to any marketing or research firms.

_____ _____

Patient / Guardian Date

_____ _____

Witness Date

Financial Policy Statement.

As a courtesy to you, we (Direct Access Therapy Inc.), will verify the insurance coverage for the requested services. Although you are responsible for the entire bill at the time when services are rendered, we will bill the insurance carrier on your behalf.

You are responsible for the required insurance co-payments, fees and deductibles and if your insurance carrier does not remit payments within 90 days, the remaining balance will be due in full from you. If the insurance carrier makes a payment to Direct Access Therapy Inc., after you have done so, a prompt refund will be forwarded to you. You are responsible for the timely payment/s for services rendered and any non-payment/s and/or delayed payment/s constitutes default.

If the insurance carrier forwards a payment directly to you for services rendered at Direct Access Therapy Inc., you will promptly remit the payment to Direct Access Therapy Inc.

By signing below, you understand the payment responsibilities of your account.

_____ _____

Patient / Guardian Date

_____ _____

Witness Date