Florida Fitness
& REHABILITATION, INC.
Hands-on approach. Skilled professionals. Proven outcomes.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for FL FITNESS & REHABILITATION to furnish medical care and treatment to considered necessary and proper in diagnosing or treating his/her physical and mental condition.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to FL FITNESS & REHABILITATION, A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

FINANCIAL POLICY STATEMENT

- We bill your insurance carrier solely as a courtesy to you. If your insurance carrier fails to make payments on your account within 60 days it will result in patient responsibility.
- We require that copays, coinsurances and deductibles be paid at the time of visit.
- Verifying secondary benefits is patient responsibility. FL Fitness and Rehabilitation will not be responsible for how secondary insurances process claims.
- A $25.00 fee will be charged for canceled or missed appointments without 24 hour notice.
- If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit payment to FL Fitness and Rehabilitation.
- A $20.00 fee will be charged for returned checks.
- Medicare beneficiaries have a cap of $ 1,780 for therapy services. (80% PAID BY MEDICARE =1,424) (20% REMAINING = $356 paid by secondary inusrance)

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

ESTIMATED INSURANCE BENEFITS

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Arrangements for payment of patient's share: ____

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient ____ Date ______/______/______