CONSENT FOR CARE & TREATMENT

I, _____, the undersigned, do hereby agree and give my consent for Capitol Physical Therapy LLC to furnish medical care and treatment that is considered necessary and proper in diagnosing or treating my physical condition.

AUTHORIZATION BENEFIT ASSIGNMENT - FINANCIAL RESPONSIBILITY- RELEASE OF INFORMATION

I authorize Capitol Physical Therapy LLC to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to Capitol Physical Therapy LLC from my insurance carrier or third party payer. I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between Capitol Physical Therapy LLC and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. 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. The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you. A photocopy of this authorization is to be considered as valid as the original. By my signature, I authorize Capitol Physical Therapy LLC to release all information necessary, including medical records, to secure payment.

_(Your Signature)_____