Manual Physical Therapy Examination:

For some muscle and bone problems it is necessary for the Physical Therapist to do a **"MANUAL PHYSICAL THERAPY EVALUATION."** This involves the Physical Therapist touching your bare skin in a firm but gentle manner to assist him/her in making an accurate diagnosis. The Physical Therapist is feeling for bony landmarks just under the surface of your skin. In some cases, this will involve the buttocks and pubic areas. The position of the boney landmarks helps your Physical Therapist make an accurate diagnosis, which helps you solve your problem.

Great care and concern is taken to observe and protect your modesty. If you desire, another person will be present during this examination and any further treatments. If you are uncomfortable, it is your responsibility to please say so to the Physical Therapist. If you would like a demonstration on a model skeleton, please inquire.

I acknowledge that I have read the information above; it has been explained to me. Furthermore, I understand the extent of the **"MANUAL PHYSICAL THERAPY EVALUATION"** to be performed. By my signature, I give written consent for a **"MANUAL PHYSICAL THERAPY EVALUATION."**

Patient, Guardian signature (if patient is under 18 years): _____
Date:_____

Private Insurance Authorization for Assignment of Benefits/Information Release:

I, the undersigned, authorize and request my insurance company to make payments of medical benefits to *CustomRehab, LLC,* for any services furnished to me by the Physical Therapist. I also authorize any billing agent acting in their behalf, to release any information necessary to process any claims on my behalf. I understand that I am financially responsible for all charges not covered by my insurance contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims or benefits.

Patient, Guardian signature (if patient is under 18 years): _____
Date:_____

MEDICARE Lifetime Signature on File:

I request that payment of authorized Medicare charges by made either to me or on my behalf of *CustomRehab, LLC* for any services furnished to me by the Physical Therapist. I also authorize any holder of medical information about me, or billing agent acting in their behalf, to release to CMS, and its agents, any information needed to determine these benefits payable for related services. I understand that I am responsible for all charges regardless of insurance coverage.

Patient signature: _____ **Date**: _____

MEDICARE Physician Visit Requirement Manifestation:

I, the undersigned, understand that I am fully responsible to ensure that I physically see my physician at least every 30 days or after 10 physical therapy treatments to ensure that I remain eligible for my Medicare Physical Therapy Benefits as described by its Law, Rules & Regulations. I further understand and acknowledge that if I do not physically see my physician at least every 30 days, I am fully responsible for the cost of my Physical Therapy Services rendered to me that will not be covered by Medicare due to my ineligibility. My signature below denotes that I have read and that I understand the information in this document.

Patient signature: _____ **Date:** _____

Office policy on Payments and Cancelations:

All therapy is due and payable when completed, unless prior arrangements have been specifically made. Finance charges will be applied on balances more than 60 days old. The charges will be computed by a periodic monthly rate of ONE AND ONE HALF (1 ½) percent (18% per annum.) A $25 charge will be applied for not showing up to a scheduled appointment or if an appointment is cancelled without a 24-hour notice. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agrees to pay all costs incurred in the said unpaid balance, including reasonable attorney's fee and related collection costs. I give my consent for the Physical Therapists of *CustomRehab, LLC* to provide therapy for myself and my dependents until otherwise noted.

Patient, Guardian signature: _____
Date:_____


CUSTOM REHAB
Individual Physical Therapy Services