



R.A.

PHYSICAL THERAPY & REHABILITATION

*Specialists who care, Results that matter,
Helping you move through life!*

PATIENT NAME: _____

Consent for Care and Treatment

I, the undersigned, hereby agree and give my consent for RA Physical Therapy and Rehabilitation to furnish care and treatment considered necessary and proper in treating my condition.

Patient Signature _____

Authorization for Signature on File and Release of Information

I, the undersigned, hereby authorize the office of RA Physical Therapy and Rehabilitation to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photostatted copy of this authorization shall be as valid as an original.

Patient Signature _____

Authorization for Assignment of Benefits

I, the undersigned, hereby assign all medical benefits, to which I am entitled, to the office of RA Physical Therapy and Rehabilitation and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay by check and mail directly to:

RA Physical Therapy and Rehabilitation

1537 South La Cienega Blvd., Los Angeles, Ca 90035

Patient Signature _____

Financial Responsibility

I understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60 days will be subject to a 1.5% finance charge, for which I am personally liable.

Patient Signature

Patient Name (please print)