Patient Name: ________________________

FOOTHILLS SPORTS MEDICINE AND REHABILITATION CONSENT

CONSENT FOR CARE AND TREATMENT

I hereby give my agreement and consent to Foothills Sports Medicine and Rehabilitation to furnish appropriate rehabilitative care and treatment, as considered necessary and in the best interest in order to attend to the physical condition. I understand that the benefits and risks to all interventions will be explained and that the patient holds the final judgment in such matters.

Patient: ________________________ Date: ________________
Signature

Parent/Guardian: ________________________ Date: ________________
Signature

FINANCIAL CONSENT

It is the policy of Foothills Sports Medicine and Rehabilitation to collect copays, co-insurance, and deductibles at the time of service. As a courtesy we verified your benefits with your insurance company. The following benefits were given to us by your insurance company and are therefore an **estimate** of your responsibility. Plan benefits given to us are as follows:

Plan: ____________________ Deductible:$ ________ Met:$_______Due:$ __________
[_] In Network [_] Out of Network

Co-Insurance _______ Copay $ ____________Cap $ ____________Cash Pay $____________
% of plan allowance | Fixed amount per visit | Accepted amount per visit | Insurance will **not** be billed

Note: ____

____

Please initial your financial responsibility below as indicated.

____[_] *Deductible*: I agree to pay the amount allowed by my plan at the time of service until my remaining deductible has been met.
initial

____[_] *Co-Insurance*: I agree to pay the **estimated** co-insurance allowed by my plan at the time of service.
initial
Estimated Co-insurance Per Visit: $ ____________

____[_] *Copay*: I agree to pay my copay of $ ____________ at the time of service.
initial

____[_] *Cap*: I agree to pay a per visit payment of $ ____________at the time of service.
initial

____[ ] *Cash Pay*: I agree to pay a per visit payment of $________at the time of service.
I understand that my insurance will NOT be billed for treatment now or in the future.
initial

I understand I will be billed for any remaining balance after all insurance companies have paid.

My plan benefits have been explained, and I agree to the above financial terms.

Patient: ________________________ Date: ________________
Signature

Parent/Guardian: ________________________ Date: ________________
Signature

Benefits Explained by:________________________ Date: ________________