DOMINION HEALTH & FITNESS, INC.

CONSENT TO TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I understand that the previous page's information is necessary to provide me with the rehabilitation treatment in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that may have been prescribed for me. By signing this agreement, I consent to have Dominion Health and Fitness provide treatment and care as prescribed by my physician and/or recommended by my therapist.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information to my insurance carrier in order to determine benefits to which I may be entitled.

PATIENT AUTHORIZATION FOR DIRECT PAYMENT

I hereby authorize Dominion Health and Fitness to apply for benefits on my behalf for services rendered by them, and request payment from my insurance carrier be made directly to Dominion Health and Fitness.

Either my insurance carrier or I may revoke this authorization at any time in writing. I permit a copy of this authorization to be used in place of the original.

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

The services you have elected to participate in may imply a financial responsibility on your part. You are responsible for payment of your deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. All co-payments must be paid at the time of service or you will need to make payment arrangements with our office manager. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurance. If your insurance carrier denies any part of your claim, or if you or you physician elects to continue therapy past your approved time period, you will be responsible for your account balance in full.

DELIQUENT ACCOUNTS: Should your account become delinquent, you will be responsible for all collection costs.

RETURNED CHECK FEE: I, the undersigned, agree to pay a fee of $25 for any check returned by my financial institution.

REFERRALS/AUTHORIZATIONS: Some managed care plans require written authorization forms from your primary care physician for each visit to a specialist. It is the patient's responsibility to make sure Dominion Health and Fitness has a valid authorization form before each visit. Failure to obtain authorization may drastically reduce your benefits/coverage with your insurance carrier.

APPOINTMENTS: All appointments should be scheduled in advance and 24 hour notice is required for cancellations. Patients who are more than fifteen (15) minutes late for a scheduled visit may not be seen depending on the discretion of the therapist. The patient may be rescheduled for a future visit if not seen.

I certify that I have read the above polices (i.e., Consent to Treatment and Authorization to Release Information; Patient Authorization for Direct Payment and statement of Financial Responsibility) and hereby give consent to each.

I understand that I may request a copy of this agreement at any time.

Signature: _____ Date: _____

Printed Name: _____

Witness Signature:_____ Date:_____