PATIENT AUTHORIZATION & GUARANTEE FORM

Release of Information:
I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, by Lyons Physical Therapy, Inc. to the physician who referred me for therapy as well as any other organization responsible for payment of my account.

Assignment of Insurance Benefits:
I hereby authorize payments of authorized benefits directly to Lyons Physical Therapy Inc., for any services that are reimbursable by Medicare or any third party sources.

Patient Responsibility for Insurance Verification:
Your contract for health insurance is between you and your insurance company. Agreements with insurance companies vary greatly, and it is **your responsibility to know if Lyons Physical Therapy, Inc. is in or out of network and what your deductible and/or co-payment is**. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. If your insurance company does not begin to pay Lyons Physical Therapy within 5 weeks of treatment, it will be your responsibility to contact them. You will receive a patient statement monthly from Lyons Physical Therapy; we expect payment from you within 15 days of the patient statement.

Valuables:
I understand that Lyons Physical Therapy, Inc. is not responsible for valuables and personal property brought to the facility.

Consent of Treatment:
I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physical may be considered necessary or advisable while I am a patient of Lyons Physical Therapy, Inc.

Guarantee of my Account:
In consideration of services rendered to me by Lyons Physical Therapy, Inc. I hereby guarantee payment for any and all services rendered to me which are not covered or allowed by insurance, together with collections costs, including reasonable attorney fees. I also understand that all bills are due and payable upon presentation. I understand that the patient responsibility portion of my bill shall be due and payable at the time of service.

Missed Appointment and Cancellation Charges:
Because we commonly have a waiting list, unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments. **There is a $25 charge for missed appointments cancelled less than 24 hours in advance**. Insurance does not pay this charge. Failure to pay no-show fees may result in discontinuity of future appointments. You are financially responsible for this fee. Please help us serve you and our community better by keeping scheduled appointments or call us in a timely manner to allow another patient to have your scheduled time.

By signing this document, I acknowledge my consent to the above.

Signature: _____Date: _____