

# FARNES

## Financial Consent / Assignment of Insurance Benefits

As a courtesy, we will bill your primary and secondary insurance company(s) if we are provided with the necessary and correct information. The Farnes Clinic acknowledges that the information received from your insurance company is not an authorization for, or guarantee of, specific action or payment. Your health insurance is a contract between you and your insurance carrier. It is your responsibility to determine what your insurance company will allow for physical therapy services, obtain prior approval if necessary and follow up with your insurance company on all unpaid visits. If your insurance requires a referral or prescription, it is your responsibility to obtain and provide us with the required information and/or paperwork before your initial evaluation and if needed subsequent treatment sessions

Co-payments are due at time of service. A \$7.50 billing fee will be charged for any co-payment that is not paid at time of service. You are more than welcome to pre-pay for your co-payments in any increment that you so wish. A receipt will be given to you at the time the payment is received. Any balance older than 60 days is subject to an interest charge of 1% per month or \$5.00, whichever is greater. All accounts over 90 days past due will be sent to Puget Sound Collection and you will be responsible for additional costs incurred. Returned checks are subject to a \$25.00 service fee that will be added to the outstanding balance.

If you do not have health insurance, we require that fees be paid when services are rendered. Likewise, if you are involved in third party litigation, fees are due at the time of service as we do not bill third party. We currently accept cash, check, Visa, and MasterCard.

I understand that I am financially responsible for all charges for services rendered regardless of litigation, insurance reimbursement or pending Labor and Industry claims. I understand that the parent accompanying a minor for treatment will be responsible for payment.

I hereby authorize Farnes Clinic and Institute to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

Client/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## Consent for Care & Treatment

I understand that Farnes Clinic is not responsible for any personal belongings that I bring into the clinic or leave in my vehicle.

I understand that if I am a Medicare or L&I client, I need to be seen by my physician every 30 days as per Federal and State guidelines. If I do not comply with this regulation, I understand I may be financially responsible for my therapy services.

Your Physical Therapist will complete an in-depth evaluation by examination and interview. Your individual treatment program and home exercise program will then be designed specific to your needs. A variety of treatment techniques may be used. I, the undersigned, do hereby agree and give my consent for Farnes Clinic to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

Client/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

## Consent for Treatment of a Minor

As parent and/or legal guardian I authorize Farnes Clinic to treat the minor patient \_\_\_\_\_.  
I understand that if the client is under the age of 16, a parent/guardian must be present for the entire treatment session.

Client/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_