PATIENT INFORMATION AND CONSENT FORM

CONSENT FOR CARE AND TREATMENT: I consent to receive an evaluation, testing and treatment at Ridgeview Physical therapy & Wellness Center. I understand that the benefits and risks to all interventions will be explained and that the patient holds the final judgment in such matters. I authorize Ridgeview Physical Therapy & Wellness Center to release any/all information regarding my medical treatment to any pertinent insurance companies, physicians or any other responsible parties.

AUTHORIZATION TO PAY: I hereby authorize insurance payment directly to Ridgeview Physical Therapy & Wellness Center, 200 Old Pond Rd, Bridgeville, PA 15017 for medical services rendered. I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable feels as may be required to obtain collection of this account. I understand that my insurance may not authorize treatment and my benefits may be exhausted during my care. If I have a managed care insurance plan, I will be responsible for obtaining referrals and/or authorization from my Primary Care Physician (PCP) for all of my therapy visits.

AUTHORIZATION TO COMMUNICATE ELECTRONICALLY: I understand that authorized personnel (including my physical therapist) from Ridgeview Physical Therapy & Wellness Center may communicate with me regarding scheduling/appointments, the treatment provided, home exercise programs, and education/informative content as it relates to my condition. I understand my protected health information (PHI) will not be communicated electronically. I understand that I have the opportunity to opt-out of future communications at any time using the "unsubscribe" option on any communication via text or email.

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document.

Printed Name: _____ Date: _____

Patient/Guardian Signature: _____ Date: _____

ELECTRONIC PAYMENTS: If you would like to receive invoices through email and make payments online, please print your email and check the box for yes. This includes coinsurance and deductibles. We are unable to accept electronic payments for any copays or self-pay rates you may have.

☐ YES ☐ NO

_____ _____

Patient Email Date