Encompass Physical Therapy, LLC
130 Admiral Cochrane Drive, Ste. 101
Annapolis, MD 21401
Ph: 410-266-1500 Fax: 410-266-1369

1) CONSENT TO TREATMENT

I, the undersigned or authorized individual acting on behalf of the patient, agree to give my consent for *Encompass Physical Therapy, LLC* to administer medical care and treatment as considered necessary and proper in the diagnosis and treatment of the patient.

2) BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or physical therapy benefits to which I am entitled, including Medicare, private insurance and any other health plan, directly to *Encompass Physical Therapy, LLC*. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

3) FINANCIAL POLICY STATEMENT

It is the policy of *Encompass Physical Therapy, LLC* to bill your insurance carrier as a courtesy to you. However, you will be held responsible for the entire bill should your insurance carrier fail to remit payment within 90 days. If payment subsequently is made by your insurance carrier in excess of the balance of your account, we will promptly refund the credit. **All co-pays, estimated deductible and/or co-insurance payments are due at the time of your visit and should be paid at the front desk prior to treatment.**

4) NOTICE OF HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

I acknowledge receipt of the facility's HIPAA practice.

In order for your therapist or other staff members of *Encompass Physical Therapy, LLC* to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so.

I authorize *Encompass Physical Therapy, LLC* to verbally release any or all information concerning my medical care to the following individuals:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Person to contact in case of emergency:

Name: _____ Relationship to patient: _____ Phone #: _____

PATIENT RESPONSIBILITY

It is the patient's responsibility to inform *Encompass Physical Therapy, LLC* of all medical conditions, treatments and medications at initial evaluation.

It is the patient's responsibility to inform *Encompass Physical Therapy, LLC* as soon as possible if there have been any changes in medical or insurance status.

My signature on this form indicates that I have read and understand each of the above patient policies *of Encompass Physical Therapy, LLC*. I have addressed any concerns I have with these policies with the office. I further understand that by not signing this form, I may be refused treatment, as these permissions are essential to the functioning of *Encompass Physical Therapy, LLC*.

Signature (Patient or Guardian): _____ Date: _____

Printed Name: _____