THE CENTER FOR BALANCE and dizziness
PHYSICAL THERAPY

CONSENT FOR CARE & TREATMENT

I hereby authorize The Center for Balance to administer such medical examination diagnostic procedures and/or treatment that, in their judgment, may indicate to be advisable for the patients wellbeing. I certify that no guarantee or assurance has been made as to the result that may be obtained. I realize I have the right to refuse any treatments or procedures to the extent permitted by law. I acknowledge that Medicine is not an exact science, no guarantees or warranties can be made to me regarding the results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purposes when my personal identity will not be revealed.

Assignment of Insurance Benefits

I authorize that the payment of my insurance benefits be made directly to The Center for Balance for any services that are reimbursable by Medicare, Medicaid or any third party payors.

Guarantee of Payment

I understand that all payments designated as "the patients responsibility" are due and payable at the time of service or billing. I guarantee that I will pay:

My designated portion including co-pays/co-insurance and my deductible

All amounts due for services that my insurance company has stated are not covered benefits

All amounts due for services billed but paid directly to me

All amounts due for services billed to a Workers' Compensation payor which was subsequently declared by my employer to be a non-eligible claim

All amounts due for claims submitted to my insurance company and not paid by 60 days

Medicare and Workers Compensation Information

I certify that the information I have provided to The Center for Balance for payment under the Social Security Act (Medicare) or under the Workers Compensation Program is correct, including but not limited to any related accidents/illness or other insurers/payors available.

Name _____ Date_____