# *Advance Spine and Pain Physical Therapy, LLC*

225 East State St. Suite 12 Trenton, NJ 08608
Tel: (609) 695-8100 Fax: (609) 695-8110 www.asappt.com


## Patient Consent

Name of Patient:_____ Insurance/HICN #:_____

Your health care at Advance Spine and Pain Physical Therapy, LLC will consist of physical therapy. We will work together with you to diagnose and treat you. You will have a therapist responsible for your care. Evaluations, daily notes and a medical history intake form will become part of your medical record. You will be informed of alternatives to treatment or return to your referring physician if PT is not appropriate for you. The benefits of physical therapy are relief of pain and increase in function. Risks, although rare, include increase of pain, decrease in function, joint injury, rash, scratches/bruises, fracture/dislocation, heart attack, concussion and rarely death. If there is any part of this form that is unclear, you may ask questions about it. I hereby request and consent to medical treatment to be given to me by Advance Spine and Pain Physical Therapy, LLC.

Patient's Signature:_____ Date:_____

If signed by any person other than patient, please specify relationship: _____

Our fees are time based or service based fees. Charges may vary from one treatment session to the next based on medical necessity. It is important for you to know you are responsible for co-payments, co-insurances and/or deductibles. If you are on Medicare, be advised Medicare only pays 80% of a covered claim. You are responsible for the 20%. Our office staff will be contacting your insurance carrier to verify eligibility. Depending on your coverage, we may be collecting money at the time services are rendered or you may receive a bill from us.

## Insurance/Medicare Signature on File Authorization

I request that payment of authorized insurance (ie. Medicare, Aetna, etc.) benefits be made on my behalf to Rita Amin, Advance Spine and Pain Physical Therapy, LLC, 225 East State St. Suite 11, Trenton, NJ 08608 for services furnished to me by the provider. Otherwise, I agree to pay all fees in accordance to the services provided to me. I authorize any holder of medical information about me to release to my lawyer/doctor and/or the insurance company/Centers for Medicare & Medicaid Services and its agents any information needed to secure the payment of these benefits or the benefits payable for related services and authorize the use of this signature on my insurance submission. I agree I know my own insurance coverage. I am responsible for charges denied by my insurance carrier.

Patient's Signature:_____ Date:_____

Witness's Signature:_____ Name: _____