



Clark Physical Therapy
2001 Westown Pkwy., Suite 107
West Des Moines, IA 50265
Telephone: 515-440-3439
Fax: 515-440-3832

Adel Physical Therapy
516 Nile Kinnick Dr. S., Suite B
Adel, IA 50003
Telephone: 515-993-5599
Fax: 515-993-1964

Clark "MFR" Physical Therapy
1454 30th Street, Suite 109
West Des Moines, IA 50266
Telephone: (515) 327-0046
Fax: 515-327-9389

CONSENT TO PATIENT INTERVENTION

CONSENT TO TREATMENT: I hereby authorize the healthcare providers of **Clark Physical Therapy** to administer such treatments, as they deem necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.

FINANCIAL RESPONSIBILITY: I agree that I am financially responsible for all charges relating to services rendered. I agree to pay all charges which are not covered by insurance or which are not promptly paid by the insurer. I understand and agree it is my responsibility to obtain prior approval required by my insurance and to take all other steps to qualify for insurance coverage. Balance of bill payment is due within 30 days of final payment by insurance company.

CO-PAYMENTS ARE DUE AND PAYABLE ON THE DATE OF SERVICE:

We accept cash, check or credit cards, including MasterCard, Visa and Discover. A \$15.00 charge will be applied for returned checks.

CANCELLATION FEE: I understand that I will be responsible for a \$25.00 cancellation fee if I do not cancel at least 24 hours prior to my scheduled appointment.

ASSIGNMENT OF BENEFITS: I hereby assign to **Clark Physical Therapy** all insurance coverage or other benefits available under any government program, any insurance policy or plan, and any other benefit program, and I direct that all benefits be paid directly to **Clark Physical Therapy**.

RELEASE OF INFORMATION: I authorize **Clark Physical Therapy** to release all medical information, via facsimile or mail required by my insurance company or Worker's Compensation carrier or designee to file for medical benefits. Additionally, **Clark Physical Therapy** may release information, via facsimile or mail, to any hospital or physician I may be referred from, or referred to, by **Clark Physical Therapy**.

Patient Signature

Date

Parent/Guardian Signature

Date