LifeQuest
PHYSICAL MEDICINE AND REHAB

Welcome to Our Clinic

At LifeQuest Physical Medicine and Rehab, we strive to meet our patient's needs. Our patient's health comes first at all times. We are always pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask any questions you may have regarding our fees or your responsibility in complying with our any questions you may have regarding our fees or your responsibility in complying with our financial policy and/ or procedures.

Limited Release of Medical Information: In the event that any insurance company or other 3rd party obligated to make payment to me or to LifeQuest Physical Medicine and Rehab for the charges made for the services, refused to make such payment upon demand, I herby assign, transfer and convey to LifeQuest Physical Medicine and Rehab any and all cause of action that might exist in my favor against such company or person. I authorize LifeQuest Physical Medicine and Rehab to prosecute said action in my name or their name to collect fees due for care rendered and legal expenses, and to resolve said claims as they see fit.

Collection/ Attorney Fees: I agree to pay all costs of collection agency, if necessary, to obtain payment in the event legal action should become necessary to collect an unpaid balance due for medical services. I agree to pay reasonable attorney fees or other such costs as the court determines proper.

Uninsured Patients: No patient will carry a personal cash balance. Payment is due when services are rendered. We gladly accept Visa/ MC, check or cash. We also offer EFT services for payment plan agreements.

Insurance Patients: Our clinic provides billing for individual or group insurance policies, personal injury claims, authorized workers' compensation, and Medicare. All recommended professional services that are covered/ limited by the **out- of- network** portion of your health insurance and are rendered to you will be charged to your health insurance on your behalf. I understand that my health insurance is a contract between me, the insurance carrier, and the provider. I understand that I am ultimately responsible for any services rendered to me that are not covered by my insurance company. I agree to pay my portion of fees at the time treatment is rendered. If your current health insurance policy is terminated for any reason and there are dates of service that were rendered prior to termination, you will also be responsible for any remaining balance.

If you receive checks in the mail for services rendered by our office, it is your responsibility to bring the checks in immediately with any supporting documents. If you do not provide the checks and/or supporting documents, you will be responsible for the entire balance due for that date of service.

Patient Name (please print):_____ Initials:_____

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Welcome to Our Clinic (cont.)

1. **General Consent to Treatments:** I herby request and consent to the performance of the indicated procedures (or on the patient below, for whom I am legally responsible) by the Doctors of Chiropractic, Medical Doctors, Nurse Practitioners and/or Doctors of Physical Therapy and assistants who now or in the future work at this office or any other LifeQuest Physical Medicine and Rehab office. Including but not limited to any and all necessary ancillary diagnostic services I have agreed to and acknowledge to have done. I have had an opportunity to discuss with the Doctors practicing in this clinic and/or with the other office or clinic personnel the nature and purpose of the procedures indicated for me. I understand that the results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic and physical therapy there are some risks to treatments, including but not limited to fractures, disk injuries, strokes, dislocations and sprains. I do not expect the Doctor to be able to anticipate and explain all risks and possible complications, and I wish to rely upon the Doctor to exercise judgment during the course of procedure which the Doctor feels at the time, based upon the facts then known to him or her, is in my best interest.
2. **Informed Consent for Injection Therapies:** By signing, I authorize LifeQuest Physical Medicine and Rehab and staff to administer injections that my healthcare provider considers reasonable and necessary. I understand that all injection treatments are commonly, but not always, accompanied by risks, including, but not limited to, bruising, temporary increase in pain, inflammation, and temporary numbness. I also understand that more serious reaction may occur, including, but not limited to: infections, allergic reactions, prolonged numbness, weakness, paralysis, spinal headache from Dural puncture, lung puncture or death as a result of or related to injection treatment. I understand that there are various types of injections that are commonplace in the practice of pain management including but not limited to trigger point, intramuscular, intra-articular (joint), tendon, ligament, nerve blocks or other forms of injections.
3. **Right to refuse treatment:** I acknowledge that I have the opportunity to discuss the nature and purpose, alternative methods or treatments, the risks, potential complications and associated risks associated with any treatment or procedure recommended by a healthcare provider of my choice. I also understand that I retain the right to refuse any particular examination, diagnostic tests, procedure, treatment, therapy or medication recommended or considered medically necessary by my healthcare provider. I also understand that due to the nature of the practice of medicine, there is no guarantee as to the results of my evaluation and treatment to my satisfaction, and I understand I may ask any additional questions I may have at any time.

I intend for this consent to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment for at this office, or any other LifeQuest Physical Medicine and Rehab clinics.

By signing below, you are indicating that you have read and understand and agree to the above conditions of this office:

_____ _____

Patient/Legal Guardian Signature Date

_____ _____

Staff Signature Date

Note: This is a confidential record and will be kept in this office. Information contained here will not be released to anyone without authorization to do so.