Seawolf Physical Therapy
12201 Industry Way, Suite 4
Anchorage, AK 99515
Phone 907-677-9653 Fax 907-677-9657
www.seawolfpt.com

Consent for Treatment / Benefit Assignment / Release of Information/Cancelation Policy

I, the undersigned, do hereby agree and give consent for Therapist Central, Inc dba: Seawolf Physical Therapy to provide medical care and treatment considered medically necessary and proper in diagnosing my medical condition.
Additionally, I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to **Therapist Central, Inc**. A photocopy of this assignment is to be considered as valid as an original. A no-show, or day-of cancelation is subject to a $100 I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

____	____
Printed Name	Signature
____	____
If applicable, minor's name	Date

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Financial Policy Statement

We bill your insurance solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance due in full will be your responsibility without benefit of deduction. From time of billing you have 30 days to pay your bill in full. If payment of due balances are not made in full within 30 days of billing a 5% monthly late charge will be added to the bill as well as a .5% monthly administration charge until the bill is paid in full. If there is no payment of your account within 120 days of your first statement the account may be sent to a collection agency. I understand that I am responsible for any court costs, collection agency fees, and/or attorney fees needed to collect monies owed to Therapist Central, Inc. dba: Seawolf Physical Therapy.

In the event that your insurance company requests refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payment is made to you by your insurance or other third party for services billed by us, you recognize an obligation to promptly remit same payment and explanation of benefits to Therapist Central, Inc. dba: Seawolf Physical Therapy.

Be advised that if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be responsible for the total amount of charges for services rendered to you.

All no-fault claims and other third party claims made by the patient must provide a secondary insurance and with this instrument signed acknowledge the right of lien by Therapist Central, Inc. dba: Seawolf Physical Therapy as the uncontested first right in payment of unpaid bills related to the care received upon settlement of claims. Therapist Central, Inc. dba: Seawolf Physical Therapy has the right to carry a .5% per month administrative fee after 90 days of unpaid bills along with the liquidated damages of 5% late fee.

*****A $100 cancellation fee is charged for appointments missed without 24 hours prior notice*****

A copy of a valid credit card may be kept on file to assist you with timely payment of your bill. A written or e-mailed notice of intent to seek payment via the card on file shall be forwarded to all accounts within the good standing grace period 7 days prior to the charge. Should the account be overdue the prior notice may be waived in order to achieve a zero sum balance of your bill.

______________________________	______________________________
Printed Name	Signature
______________________________	______________________________
If applicable, minor's name	Date