Pioneer Therapy Center

Client Consent Form

Welcome to Pioneer Therapy Center. This clinic is committed to providing comprehensive rehabilitation services that restore physical function and improve quality of life. Therapy has been ordered for the client named below and/or client is initiating treatment independently. In order to initiate services, we need your initials and signature on this authorization form. Please read and sign where indicated below. Please make us aware if you would like a copy of this form.

Client Name_____**Date:**_____

Authorization for Treatment and Release of Information: I consent for this provider to render the treatment set forth above ordered by my physician or myself.

1. I give authorization for therapy to be provided in areas not totally isolated from other clients and personnel.
2. I understand that I am free to choose my occupational therapy provider independent of insurance plans, referring physicians and have elected to choose Pioneer Therapy Center
3. This authorization, or photo copy of the same, authorizes the release of any and all medical information to general medical insurance and all workers compensation insurance companies necessary for treatment and/or to process claims.
4. For any other circumstance other than the three listed above, a separate signed release will be required to authorize this office to release any information.

I have read and understand the above.

Signature of Client or Client Representative:
_____

Name of Representative:
_____

Consent for Photographs: I hereby authorize Pioneer Therapy Center to take photographs of me for the use in treatment to monitor progress with my condition, to assess splinting and taping needs, for the use for educational purposes as well for our website and/or Facebook page. I understand that none of my personal information about me will be disclosed for privacy laws that are in place. I understand by giving my permission for the use of photographs will in no way hinder the quality of care provided. I hereby release Pioneer Therapy Center from any liability associated with the use of the photographs provided and described above.

Client Signature or Client Representative: _____**Date:** _____

Reimbursement Coverage: I request and authorize the client's insurance coverage to make payments of authorized benefits on the client's behalf directly to this provider.

1. I understand that I am ultimately responsible to pay for services provided to the client including any of the following:
    a. Any applicable deductible or co-payments.
    b. Any non-insured or non-covered services authorized.
    c. Any charges in excess of payment limitations imposed by third party.
2. I understand that any amount not paid within 60 days including payments by your insurance company will be subject to a monthly billing service charge of 1% per month in addition to any fees associated with collections including legal fees.

I have read and understand the above.

Signature of Client or Client Representative: _____

Date: _____

Name of Representative: _____

Relationship _____