ADVANCED THERAPY SOLUTIONS, INC.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for ADVANCED THERAPY SOLUTIONS to furnish medical care and treatment considered necessary and proper in diagnosing or treating his/her physical and mental condition. Please check your preference:
___Yes, allowed to leave a private message on phone number (_____)_____-_____.
___No, not allowed to leave a private message.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to **Advanced Therapy Solutions**. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

BILL OF RIGHTS/CANCELLATION/NO SHOW POLICY

I acknowledge I have received and read the Patient's Bill of Rights. When an appointment is scheduled with the therapist, time is specifically allocated to you. PLEASE NOTE: When an appointment is not canceled in advance, and the patient does not show up, it does not allow for other patients in critical need of care the opportunity to be seen sooner. We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel your appointment. **If you do not cancel before the end of the business day PRIOR to your appointment (and there is no medical reason) you will be charged a $35.00 fee. If three appointments are missed without contacting us, you will be dismissed from the practice for non-compliance.**

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. **You are responsible for your estimated share when services are rendered. We require that arrangements for payment of your estimated share be made today. We accept cash, checks, credit cards and Care Credit.** If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.
If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the same to ADVANCED THERAPY SOLUTIONS. When you pay by check, you expressly authorize ADVANCED THERAPY SOLUTIONS, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax).
I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees. **It is very important that you understand the provisions of your policy.**

PLEASE NOTE: The following is an estimation of benefits, not a guarantee of payment.

Benefits are determined at the time claims are processed and are subject to change. It is the patient's responsibility to determine if the estimation of benefits is correct. Advanced Therapy Solutions encourages the patient to call the insurance company to determine correct benefits.

NOTE: Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance. The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

_____ _____
Patient/Guardian/Responsible Party **Date**

_____ _____
Office Representative/Witness **Date**