28 Nolan Cove, Suite A, Jackson, Tn 38305 (731) 512-0302

1. As a courtesy to our patients, we will complete any necessary reports and file them with your insurance company to help you collect. *It is in your best interest for you to call your insurance company to get your "Outpatient Physical / Occupational Therapy" benefits, so that you understand and are aware of any coverage limitations or restrictions.*

2. However, I understand that Redden Total Therapy does not accept any responsibility for collection of my insurance benefits, or negotiating the settlement of a disputed claim. *I am responsible for all charges, regardless of anticipated insurance coverage.*

3. I understand that my account is considered delinquent if over 90 days old and may be sent to an outside source for collection. I agree to pay collection costs and/or attorney fees associated with collecting my delinquent account.

4. Once the therapist has determined the nature of your problem, treatment plans will be discussed with you. The office staff will advise you of the estimated cost of treatment, at your request. *The patient is responsible for all deductible, co-pay, co-insurance, and other charges not covered by the insurance company at the time of service.*

5. If your health problem is the result of an auto accident, you must provide to us all insurance information of the responsible party and all attorney information. You must also provide to us the patient's major medical policy information. We file all auto and major medical claims simultaneously. Overpayments from the insurance company will be reimbursed at the end of care.

6. Informed Consent: I understand that as a patient of Redden Total Therapy

* I have the right to receive complete and current information concerning my diagnosis (to the degree known by Redden Total Therapy), treatment and any known prognosis. This information will be communicated to me in terms I can understand by my therapist.
* I have the right to accept medical care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences if I refuse treatment. I understand that if I refuse recommended treatment, Redden Total Therapy has the right to terminate the relationship with me.
* I will be informed if Redden Total Therapy wishes to participate in or perform any research or educational projects that would affect my care. I understand that I have the right to choose whether I participate. I will receive the most effective care the clinic provides.
* Patient's Rights will be posted in a prominent location for my review, and I can discuss any questions I have with my therapist.

7. Privacy Policy: I understand there is a copy of Redden Total Therapy's privacy policy posted and it is my right to request a copy of the policy. I also understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my health information to another entity (my doctor, insurance company, etc.) and I consent to such disclosure for these permitted uses, including via fax. **Initial _____**

Is there anyone (family, spouse, children, friend) involved in your care or payment related to your care that we can share your health information with? ___ No ___ Yes please specify: _____

May we contact you by phone for appointment reminders? ___ No ___ Yes

I have read, understand, and agree to all the above.
Patient's Signature _____ Date _____

Assignment of Benefits: I hereby assign all benefits directly to Redden Total Therapy and also authorize release of any medical records necessary to process medical claims. I understand fully that in the event my insurance company or financially responsible party does not pay for the services, I will be financially responsible for payment. Any overpayment will be reimbursed at the end of treatment.

Patient's Signature_____ Date _____