Comprehensive Therapy Solutions
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CONSENT FOR CARE AND TREATMENT

Welcome to Comprehensive Therapy Solutions! Our therapists have advanced knowledge and training in upper extremity orthopedics and look forward to working with you in your rehabilitative needs. Your participation in therapy and your home exercise program is a vital component in this process. Together we will maximize your functional performance and achieve your rehabilitation goals. If you need to cancel or change an appointment, please make every effort to do so within 24 hours of your appointment date. Co-pays/deductibles will be collected at each therapy visit. Thank you!

I hereby authorize Comprehensive Therapy Solutions to provide rehabilitation services to:

_____ _____ _____
Patient's Name Date Patient/Guardian Signature

I hereby authorize Comprehensive Therapy Solutions to release any necessary medical records and information related to my care.

_____ _____
Patient/Guardian Signature Date

We will gladly bill your insurance carrier as a courtesy to you. You may be responsible for an estimated share based on your insurance policy, which will be collected at each therapy visit. You may be billed for any outstanding balance or fees, which have not been paid by your insurance company within a 60-day period.

Patient is responsible for _____ per therapy visit.

I agree with the above financial policy and approve insurance payments to be sent directly to Comprehensive Therapy Solutions.

_____ _____
Patient/Guardian Signature Date