Eclectic Physical Therapy
Jennifer Iannucci, MPT

Balance Dynamics PT
Anne Wolf, MPT

CONSENT FOR CARE AGREEMENT

I, the undersigned, do hereby agree and give my consent for Trumbull Physical Therapy & Wellness (Eclectic Physical Therapy and Balance Dynamics PT) to furnish medical care and treatment to (patient name) _____ which is considered necessary and proper in the diagnosing or treating my physical condition.

Patient/Guardian BENEFIT ASSIGNMENT/RELEASE OF INFORMATION I, the undersigned, hereby assign all medical benefits, including Medicare, private insurance, major medical benefits, Worker's Compensation and any other health plans to which I am entitled to Trumbull Physical Therapy & Wellness. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Trumbull Physical Therapy & Wellness to release all medical information and records as necessary to secure payment for services rendered.

Signature (Patient/Guardian) _____ Date_____

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the bill when services are rendered. Required co-payments and estimated co-insurances are to be made as services are rendered. If any payments of medical benefits are made directly to you for services rendered by Trumbull Physical Therapy & Wellness, you must promptly remit such payment. If you do not have health care benefits or elect to be "self-pay," you are expected to pay at the time of service. For your convenience, we accept cash, checks and credit/debit cards. If you pay by check, and your check is returned for any reason, we will expect payment in full plus a return check fee of $30.00 within 30 days of the returned check.

Signature (Patient/Guardian)_____ Date_____

6527 Main Street, Lower Level Trumbull, CT 06611
jen@TrumbullPTandWellness.com
Anne@TrumbullPTandWellness.com
Fax: 203-549-0613