Michigan THERAPY Institute

Quality, compassionate physical therapy for optimum results

Service Agreement / Consent for Treatment / Evaluation

I, the undersigned:

Voluntarily consent to treatment or evaluation as recommended and fully explained to me by the staff of the Michigan Therapy Institute, and understand that I am free to withdraw my consent and discontinue treatment at any time.

I hereby certify that I understand that the treatment or evaluation _____ may/will receive at Michigan Therapy Institute, through its staff, is based on current standards of care of rehabilitation services. I also understand that the result of such treatment cannot be warranted or guaranteed. I hereby voluntarily apply for consent to treatment and/or evaluation.

I authorize Michigan Therapy Institute to submit billing statements to my insurance carrier for the purpose of receiving reimbursement for services. This authorization to file for services to my insurance carrier shall remain in effect until the Michigan Therapy Institute has recovered full payment for all services provided to me. I fully understand that I am responsible for all medical bills submitted by the Michigan Therapy Institute for services rendered to the above mentioned patient. Furthermore, I agree to pay for any co-pays and or deductibles as required by my insurance company. I also agree to pay for any services which are not a covered benefit under my insurance policy.

I authorize my insurance company to pay directly to Michigan Therapy Institute (hereinafter referred to as MTI) and to no one else, benefits due me either under the terms of my policy or insurance or a policy of insurance which, by operation of law, I have become an “insured”.

I understand that the information shall be considered confidential, but may be released to my insurance company for the purpose of billing or to auditing agencies to assure that I am receiving quality care. This may include information such as, dates of service and person(s) seen. I authorize the release of this information. A report of my evaluation will be sent to my insurance company and to any other person I have authorized.

By signing this document you agree that you have read, fully understand and agree with this document.

_____ _____

Signature of Patient or Guardian Date

_____ _____

Witness Date