Admission Agreement

CONSENT TO TREAT
I have been informed of the treatment considered necessary and that such medical care, treatment, and procedures will be performed by medical pros ideas, house staff, and employees of Therapy Essentials, LLC. I hereby grant my authorization and consent to such treatment and procedures, and certify that no guarantee or assurance has ben made as to the results which may be obtained.

RELEASE OF MEDICAL INFORMATION
I understand that all records concerning my health care remain at the property of Therapy Essentials, LLC. I authorize Therapy Essentials, LLC and the therapists providing care hereunder to release any medical information or statement of charges in connection with these services to, but not limited to, an insurance carrier, workers compensation carrier, health and welfare funds or that patient's or responsible party's employer for the purpose of obtaining payment or to determine the appropriateness of treatment. If I am transferred to another physician/facility, I give consent to have my health records released verbally, via fax machine, secure email or via photocopy for continuing of care.

PATIENT RIGHTS
I have received a copy of Therapy Essentials, LLC Patient Rights upon admission.

FOR MEDICARE AND MEDICAID BENEFICIARIES
I certify that the information given by me in applying for payment under Titles XVII and XIX under the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf for any services furnished by me by or in Therapy Essentials, LLC. I authorize any holder of medical or other information about me to be released to the Healthcare Financing Administration and agents any information necessary to determine these benefits or related services. I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by, or in Therapy Essentials, LLC.

AGREEMENT TO PAY FOR SERVICES
For and in consideration of the care and treatment provided to the patient, the undersigned agrees to pay Therapy Essentials, LLC all charges for services rendered to or on behalf of the patient.

AGREEMENT OF INSURANCE BENEFITS
I hereby assign medical benefits of any type whatsoever arising out of any policy of insurance insuring to patient or any other party liable for the patient's care to Therapy Essentials, LLC to be applied to the charges for services rendered. I understand that I am financially responsible for charges not covered by this agreement and further agree to guarantee full payment of all expenses not covered by third-party payers.

I have read the above authorizations and agreements and I fully understand the same.

_____ _____
Patient or Authorized Signature Date/Time

_____ _____
Relationship to Patient Witness