Creighton
THERAPY AND WELLNESS

CONSENT TO TREAT/FINANCIAL AGREEMENT

Patient's Name_____

DOB_____

MRN_____

I hereby consent to the evaluation and treatment of the above-named patient by a licensed occupational therapist (OT), physical therapist (PT) and/or speech therapist (ST) of Creighton Therapy and Wellness: Occupational, Physical and Speech Therapy (CTW). The course of therapy will be as determined necessary by the therapist(s) and, as needed, the referring physician. I understand and agree that CTW makes no guarantee as to the results of the occupational, physical and/or speech therapy.

I understand that CTW is part of Creighton University's School of Pharmacy and Health Professions, which has teaching and research activities. I understand that students and other health care professionals may come to CTW to learn, observe and perform the treatments being provided by my or my child's therapist(s). I consent to students and other professionals participating in my or my child's therapy sessions.

I hereby assign and transfer to CTW the right to all third party payments (including Medicaid, Medicare and/or private insurance benefits) to which I or my child may be or become entitled to for the therapy services provided. I authorize CTW to apply and file for all such benefit payments on behalf of myself or my child and direct that such payments be made directly to CTW. I will pay to CTW any such insurance benefit payments received by me for services rendered by CTW.

I understand that I am responsible for payment of all charges for therapy services received by me or my child. If the therapy services are covered by insurance, I understand that I will be responsible for payment of any deductible, co-payments or co-insurance required by the insurance company. I understand that I am advised to fully know and understand my or my child's insurance benefits prior to receiving therapy services. I understand that all insurance plans are different and some plans limit therapy services. I agree to pay all charges for services if I receive or my child receives therapy services not covered by insurance.

I have read and fully understand this form. I have been given the opportunity to ask questions and all of my questions have been answered to my satisfaction.

_____
Patient or Guardian Signature

_____
Patient or Guardian Printed Name

_____
Date