Orthopedic Physical Therapy Specialists, Inc.

Dr. Karl J. Sheaffer PT DPT

Lehigh Valley Office Plaza
1150 Glenlivet Dr. Suite A-14
Allentown, PA 18106
Phone 610-336-4300
Fax 610-336-0971
www.optsinc.com

Consent To Treat
I hereby consent to the provision of care, diagnosis and/or treatment by Orthopedic Physical Therapy Specialists, Inc., Lehigh Valley Office Plaza, 1150 Glenlivet Dr., Suite A14, Allentown, PA 18106 and I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing. I hereby acknowledge and confirm that I am mentally capable of giving consent to the provision of the care, diagnosis and/or treatment and am not subject to duress or under undue influence.
Signature Patient/patient representative_____
Date_____

Insurance Authorization and Acceptance of Financial Responsibility
I authorize the release to my insurance company(s) any information necessary to process my insurance claim. I understand that in executing this authorization I waive the right for such information to be privileged. I also authorize payment of medical benefits to be made directly to Orthopedic Physical Therapy Specialists, Inc., Lehigh Valley Office Plaza, 1150 Glenlivet Dr., Suite A14, Allentown, PA 18106. A photocopy of this authorization shall be considered as valid as the original.
I agree to accept financial responsibility for any services provided by OPTS, INC. _____initial

Non Participating Provider and Valid Insurance Referral
I accept responsibility for all outstanding balances for services, rendered by Orthopedic Physical Therapy Specialists, Inc., that may occur if my health insurance company determines that Orthopedic Physical Therapy Specialists, Inc. is not considered a participating provider in my health insurance's network.
I also accept responsibility for any outstanding balances that may occur if my insurance requires a referral and I do not have a valid referral for the services provided by Orthopedic Physical Therapy Specialists, Inc.
_____**initial**

Payment Policy/Credit Card on File Policy
All copays are expected at time of service and monthly invoices are due within 30 days of billing date. In the event an invoice becomes 30 days or more past due, it will be placed with Hamilton Law Group for collection. I/we agree to pay a service charge of 1.5% per month (18% APR), and any and all collection attorney fees of 35% on the unpaid balance and interest. _____**initial**

Credit Cards on File will be used to pay account balances after insurance adjudication. Once your insurance has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our office showing what your total patient responsibility is. You typically receive the EOB before we do, so if you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier immediately.
By accepting responsibility, I realize that I will be billed for any balances on my account left unpaid by my insurance company. You signature below acknowledges you understand the financial policies described above.

Signature: **Date:**

Print Name: **Witness Signature:**