Back-in-Action
REHABILITATION, S.C.

Date:

To Whom It May Concern:

Mutual agreement has been made between Back-In-Action Rehabilitation and myself, , for an agreed upon cash contract for Ala Carte services. Secondary to alterations and changes in my personal existing economies not the least of which may include loss of insurance, loss of job with either myself or my spouse and/or decrease in financial income, this contractual agreement is being made. In light of this, Back-In-Action Rehabilitation and myself have agreed to a private pay rate for services rendered, with the amount to be paid at each visit. This agreement is effective on the date signed below.

Consent to Treat. You are authorizing Back-in-Action Rehabilitation to provide treatment. You acknowledge that no guarantees have been made as a result of any therapy treatments or evaluations administered or prescribed by our clinic, nor can they be. You understand that although you may be discharged from treatment, it is your responsibility to seek follow-up care when necessary and that your condition may continue to require maintenance therapy.

Returned Checks. A $25 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

Privacy Notice. By signing below, you are acknowledging that you have had full opportunity to read and consider the contents of our Privacy Notice.

Missed appointments/Late Cancellations. Our policy is to charge *$25 for missed appointments* not canceled within a reasonable amount of time (24-hour notice). These charges will be your responsibility and billed directly to you; they are not covered by insurance. Please help us to serve you better by keeping your regularly scheduled appointment. When cancelling your appointment, you must inform the staff of the reason for cancellation – if deemed to not be an emergency, your account will be charged $25 for the missed appointment.

Please also indicate if you have a Doctor that you would like the notes sent to:

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our policies. Please let us know if you have any questions or concerns.

By signing below, you certify that you have read the entire document, understand its contents and significance, accept responsibility for payment, and agree to abide by its guidelines:

_____ _____

Patient Signature Date

_____ _____

Back-In-Action Rehabilitation Date

If patient is a minor or unable to consent, complete and sign the following:
Patient is unable to sign because
(provide
reason)_____

Signature:
_____

Person signing on behalf of patient Relationship to patient

Witness: _____

Back-in-Action accepts Visa, Mastercard and Discover for your convenience.

Back-In-Action▲ 103 South Pioneer Road ▲ Fond du Lac, WI 54935 ▲ 920.922.7776 ▲ FAX 920.922.2938
Back-In-Action▲ N8218 State Rd 28 ▲ Mayville, WI 53050 ▲ 920.387.9000 ▲ FAX 920.387.5835
Back-In-Action▲ 1057 Fond du Lac Avenue ▲ Kewaskum, WI 53040 ▲ 262.626.6700 ▲ FAX 262.626.1078
Back-In-Action▲ 1401 Milwaukee Drive ▲ New Holstein, WI 53061 ▲ 920.898.4440 ▲ FAX 920.898.4466
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