Home Therapy
Resources Inc

6715 East 41st Street
Tulsa, OK 74145
Phone: 918-806-0106
Fax: 918-806-0113

CONSENT FOR TREATMENT

Patient Full Name: _____ **Date of Birth:**_____

I, the undersigned, do hereby authorize and give my consent for ***Home Therapy Resources, Inc.*** to provide Occupational, Physical and/or Speech therapy services including patient evaluation and therapy sessions as recommended by Home Therapy Resources, Inc.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical benefits/payments which I/my child am/is entitled, including Medicaid, private insurance and third party payers to ***Home Therapy Resources, Inc.*** for services rendered. I hereby authorize ***Home Therapy Resources, Inc.*** to release all information to my insurance company, per their request, necessary for processing my insurance claims. I authorize provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

FINANCIAL AND HEALTH INSURANCE POLICY

Home Therapy Resources, Inc. appreciates you selecting us to meet your child's therapy needs. These services imply a financial responsibility on your part. ***Home Therapy Resources, Inc.*** will verify your coverage/benefits and bill your insurance carrier on your behalf. However, it is ultimately your responsibility for the payment of all services received.

You are responsible for payment of any co-payments at the time of services. You are also responsible for payment of deductibles and/or co-insurance upon receipt of a bill from ***Home Therapy Resources, Inc.*** If you do not have insurance, it is expected that all fees will be paid on a regular basis before therapy visits as determined by ***Home Therapy Resources, Inc.*** A discount will be provided if you do not have insurance coverage. ***Home Therapy Resources, Inc.*** understands special needs. If special arrangements are needed, please contact our office at 918-806-0106 to discuss the matter with our billing department as soon as possible so specific arrangements can be agreed upon. If you have any questions, please feel free to ask. We are here to help you.

I have had an opportunity to read and understand the Financial and Health Insurance Policy Statement of ***Home Therapy Resources, Inc.*** *and am agreeable to all the policies stated. I understand my responsibility for full and prompt payment on my account.*

Signature _____ **Date** _____

Relationship to Patient: _____