A.R.I.
ADVANTAGE REHAB INC.
700 Cedar Street Suite 153 Alexandria, MN 56308 320-219-9680

Consent to Care, No Show Charge, Change of Insurance, and Cancellation Policy
Please read this very carefully. Due to past circumstances we are enforcing the following

Consent to Care/90 Day: In signing this Consent to Care, I am agreeing to the recommendations and options for appropriate care from the Physical Therapist of Advantage Rehab Inc. all of my questions regarding a treatment plan, fees for service and options for care have been answered to my satisfaction. In signing this form, I consent to the treatment plan discussed with me which may include but is not limited to; modalities, massage, ultrasound, manual therapy, mechanical traction, or any other procedures recommended by the therapist. I understand that I may terminate this agreement at any time, and that all fees for service rendered me prior to a signed notification of termination are due and payable at that time or when billed at the end of the month. I also understand that at all times I am in control of my health care and all of the decisions pertaining to that care, I have chosen the therapists and staff of Advantage Rehab Inc to assist me in my health care.
AFTER 90 DAYS: *Our therapists will reevaluate your plan of care. In order for your insurance to continue covering your care we have to state specific goals and document progress. If after 90 days you are receiving "maintenance" type care, you will be discharged from therapy. This does not mean that you cannot return for therapy. It is recommended that you wait at least 90 days and then return again if needed for further care to evaluate again. If a new injury occurs this would not be included in the 90 days and you would be able to return with no concern to insurance.*

No Show Charge of $60: By my signature on this form I am also stating that I have been made aware of the “no show” charge for this facility. If I am unable to make my appointment or choose not to come and know this however I neglect to call ARI to cancel my appointment I consent to a $60.00 that will be added and billed to me for the time missed. In the past this has been an issue therefore this has now been put into place to avoid repeated missed appointments that could be utilized by another patient.

Change of insurance coverage: By my signature on this form I am also stating that I have been made aware of the importance in letting ARI know if I have had any changes in my insurance coverage. If there is a change I will inform ARI immediately of this change in carriers. Failure to do so will result in a fee of $50.00 that will be charged to the patient account. This charge is put in place due to the amount of time it takes to correct all of the claims and resubmit them.

Cancellation Policy: ARI now holds a cancellation policy. By my signature I am stating that I will hold the appointments I have scheduled or cancel 24 hours prior to my scheduled appointment. If I fail to do this I understand that I will be charged $60.00. We need to use our time here for those who are in need of our consistent care.

We are sorry these fees have to be implemented at our facility. Due to many circumstances in the past, we need to hold the patient at a greater responsibility. Thank you for your understanding. -ARI

Name Printed: _____

Signature:_____ Date of Signature:_____