**La Luz Therapies, LLC.**

**Patient Consent to Treat and Bill**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First M.I. Last

**Applies to Insurance Claims and any other Non-Medicare Claims:**

I, as the patient or responsible party for Patient, authorize treatment by and payment of medical benefits to La Luz Therapies, LLC., for therapy services rendered as ordered by Patient’s Physician. I understand that La Luz Therapies, LLC. Will “TAKE ASSIGNMENT” of all insurance benefits payable with respect to all services rendered.

I understand that the provider of services will bill Patient’s primary insurance company for 100% of coverage of services rendered.

I ACKNOWLEDGE that La Luz Therapies, LLC….

1. Has given me and I have read a copy of the Patient’s Bill of Rights;
2. Will provide the Patient Physical, Occupational, or Speech and Language Therapy on the referral of the Patient’s Physician;
3. Is responsible for the provisions and supervision of services it provides;
4. Will submit claims to the appropriate insurer for payment of its charges for services rendered to Patient, and submit invoices to the Patient or responsible party for any amount not paid by such insurer, including any deductible or co-insurance amount,
5. Will make available upon request its current charge for Pediatric Physical, Occupational, and/or Speech and Language Therapy;

I am aware of my rights under the law to refuse any and all medical treatment. I hereby consent to the treatment[s] described

***I acknowledge receipt of a copy of the La Luz Therapies, LLC. notice of Privacy Practices.***

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Signature of Patient or Responsible Party Date