

“NOTICE OF PRIVACY PRACTICES”

Acknowledgement of Receipt

By signing this page, I acknowledge having received the HIPAA notice that describes how medical information about me may be used and disclosed.

Patient Name: _____

Signature: _____

Relationship to Patient: _____ Date: _____ Witness: _____

I, _____, hereby allow Arthritis and Sports Physical Therapy to release my private healthcare information to (Spouse, Children, Other): _____, _____.

ASSIGNMENT OF INSURANCE BENEFITS

A staff member of Arthritis & Sports Physical Therapy has reviewed my benefits with me. I understand that this explanation of coverage was obtained from my insurance company as a courtesy and is not a guarantee of coverage. I do not hold Arthritis & Sports Physical Therapy responsible for any incorrect or omitted information or for any changes in my future coverage. If coverage is not a direct contract; or if the information provided by my insurance company is not accurate or the insurance company changes its coverage, I agree to be fully responsible for payment for services. I understand that I can verify this information by reading my insurance benefits book or contacting my insurance company directly.

As the patient whose name appears below, I hereby authorize Arthritis & Sports Physical Therapy. to file on my behalf for payment of any medical benefits arising out of any insurance covering me and hereby assign the benefits to Arthritis & Sports Physical Therapy for application on the patient's bill. I certify that the information reported with regard to my insurance coverage is accurate and complete and further authorize the release of necessary information, including medical information, for this or any related claim of medical benefits. I permit a photocopy of this authorization to be used in place of the original.

I understand that I am liable for payment to Arthritis & Sports Physical Therapy., all co-insurance co-pays and deductibles as required by my insurance and participating agreements (if any) between the insurance carrier and Arthritis & Sports Physical Therapy. Further, I will be responsible for payment of charges not covered by my insurance plan.

Payment is requested at the time services are rendered. If expensive or extended treatment is anticipated, arrangements may be made for a payment plan. Arthritis & Sports Physical Therapy. will bill charges to the primary and/or secondary insurance carrier, and Arthritis & Sports Physical Therapy will bill the remaining amount to the patient. Any balance due, for whatever reason, i.e. co-payments, failure to have proper referral, denial of worker's compensation benefits, is the patient's responsibility. Payment for charges which are the patient's responsibility are to be paid within 30 days. The patient and/or guarantor signing below accept responsibility for payment. Should the patient's account be turned over for collections/and or an attorney for payment due, the patient and/or guarantor shall pay any collection costs and 33% attorney fees. The patient and the guarantor agree to be responsible for and to pay interest of 18% on any unpaid balance due to Arthritis & Sports Physical Therapy. The office manager of Arthritis & Sports Physical Therapy will gladly assist you with any aspect of this policy.

Patient/Guardian Signature

Date

Witness Signature

Date