PROGRESSIVE STEP REHABILITATION of ORANGE PARK

AUTHORIZATION TO RELEASE OR RECEIVE MEDICAL INFORMATION AND AUTHORIZATION OF ASSIGNMENT OF BENEFITS

Our staff strives to provide you with the highest quality care available and your cooperation is an essential part of your recovery. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.

OUR PROFESSIONAL SERVICES ARE RENDERED TO YOU, NOT YOUR INSURANCE COMPANY, THEREFORE PAYMENT FOR TREATMENT IS YOUR RESPONSIBILITY.

I understand that I am fully responsible to this facility for charges not covered by my insurance company. I further understand that such payment is not contingent on my settlement, judgement or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay my account in full, or no payment is made within 60 days, the remaining balance is my responsibility. I further understand and agree that I will be responsible for all costs of collection if my account becomes delinquent and must be turned over to a collection agency. A charge of $25.00 is applied to all returned checks.

Please initial each item.

1. ____ I authorize this office to release or receive any information necessary to expedite insurance claims.
2. ____ I authorize this office to obtain medical information from my physician.
3. ____ I authorize this office to bill my insurance company.
4. ____ I authorize payment directly to this facility of any insurance benefits otherwise payable to me.
5. ____ In the event I receive payment from my insurance carrier, I agree to endorse said payment to this facility.
6. ____ Payment for work comp claims is the responsibility of the work comp carrier.
7. ____ I consent to physical therapy treatment.
8. ____ I agree to keep scheduled appointments and understand that if I miss more than 3 appointments, my therapist may require me to return to my physician before continuing.

Any appointment not cancelled within 24 hours will be charged a no show fee of $25.00.

EQUIPMENT AND THERAPY SUPPLIES that are issued to you or used by you during the course of your treatment may not be reimbursed by your insurance company. These may include such items as electrodes, exercise booklets, cold packs for home use, lumbar cushions, orthotics, splints, braces and other items. Most insurance companies do not cover these supplies and payment will be expected upon receiving these items. You will be advised in advance.

I understand and consent to the above: _____

Patient/Guardian Signature

NOTICE OF PRIVACY PRACTICES

We are required by law to make certain that health information identifying you is kept private. You have been given the opportunity to read how your health information in this office may be used and/or disclosed and how you can get access to this information. I have read the Progressive Step Notice of Privacy Practices and a printed copy has been given to me.

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Patient/Guardian Signature