

Advantage Hand Therapy & Orthopedic Rehabilitation, LLC

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Advantage Hand Therapy & Orthopedic Rehabilitation, LLC to furnish medical care and treatment to _____ which is considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Responsible Party/Parent/Guardian _____ Date _____

BENEFIT OF ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payors to Advantage Hand Therapy & Orthopedic Rehabilitation, LLC. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Advantage Hand Therapy & Orthopedic Rehabilitation, LLC to release all information necessary, including medical records to secure payment.

Responsible Party/ Parent/Guardian _____ Date _____

FINANCIAL POLICY STATEMENT

You are responsible for the entire balance of your bill. We shall bill your insurance carrier solely as a courtesy to you. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your insurance company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services rendered by us, you recognize an obligation to promptly remit the same to Advantage Hand Therapy & Orthopedic Rehabilitation, LLC.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Responsible Party/ Parent/Guardian

Date

Center Representative/Witness

Date