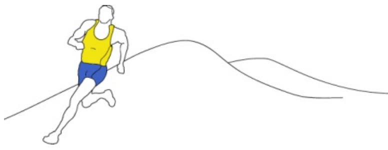

UPPER PERK PHYSICAL THERAPY & SPORTS REHAB., INC.
NEW HOPE PHYSICAL THERAPY
CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my con sent for **Upper Perk Physical Therapy & Sports Rehab., Inc./ New Hope Physical Therapy** to furnish medical care and treatment to_______________________________, considered necessary and proper in diagnosing or treating.

_______________________________________ ___________________________
Patient/Guardian/Responsible Party **Date**

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payors to **Upper Perk Physical Therapy & Sports Rehab., Inc./New Hope Physical Therapy**. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

_______________________________________ ___________________________
Patient/Guardian/Responsible Party **Date**

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. 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 request a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your 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 billed by us, you recognize an obligation to promptly submit same to **Upper Perk Physical Therapy & Sports Rehab., Inc./New Hope Physical Therapy.**

The above may 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 held responsible for the total amount of charges for services rendered to you.

When you pay by check: you expressly authorize **Upper Perk Physical Therapy & Sports Rehab., Inc./ New Hope Physical Therapy, (if your check is dishonored for any reason)** the right to charge you a returned check fee of $25.00 for the processing fee plus the amount of your check. The above language authorizes an electronic debit to your account for the recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not, however, mean that **Upper Perk Physical Therapy & Sports Rehab., Inc./New Hope Physical Therapy** cannot collect a returned check fee by other methods.

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

Information Privacy: **Upper Perk Physical Therapy & Sports Rehab., Inc./New Hope Physical Therapy** will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. The undersigned acknowledges receipt of this information.

I UNDERSTAND MY RESPONSBILITY FOR THE PAYMENT OF MY ACCOUNT

_______________________________________ ___________________________
Patient/Guardian/Responsible Party Date

_______________________________________ ___________________________
Center Representative/Witness Date