CONSENT TO TREAT AND AUTHORIZATOIN TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS, FINANCIAL RESPONSIBILITY, SELF PAY

\_\_\_\_\_ TREATMENT CONSENT: I hereby authorize Certified Hand Therapy Services, LLC, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition.

\_\_\_\_\_ AUTHORIZATION TO RELEASE INFORMATION: I further authorize Certified Hand Therapy Services, LLC to furnish the appropriate agencies, for the purpose of billing, any information acquired during the course of my treatment and to send me notices and reminders of my appointments via text message, phone call or email. I acknowledge that Certified Hand Therapy Services, LLC is released from all legal liability that may arise from release of my medical records.

\_\_\_\_\_ ASSIGNMENT OF BENEFITS: I agree to assign my therapy benefits to Certified Hand Therapy Services, LLC and authorize my insurance carrier to make payments to Certified Hand Therapy Services, LLC on my behalf. It is my responsibility to inform the facility of changes to my insurance, name, address and phone number.

\_\_\_\_\_ FINANCIAL RESPONSIBILITY: I understand that I am responsible for payment of my account and I do hereby guarantee payment in full on my account with Certified Hand Therapy Services, LLC for treatment and services rendered. Certified Hand Therapy Services, LLC does not take responsibility for negotiating settlement of disputed claims. I understand that all copayments, deductibles, and/or coinsurance is to be paid at time of service. All balances that accrue after insurance payment is received is due upon receipt. If the account is referred to an attorney for collections, the undersigned agrees to pay all attorney fees, court costs, legal and lawful collection costs in addition to all other sums due.

\_\_\_\_\_ ASSIGNMENTS AND AUTHORIZATION TO BILL MEDICARE: If I am a patient covered under Medicare/Medicaid program, I understand that I am responsible for 20% of Medicare Part B services. I hereby assign and authorize payment to be made directly to Certified Hand Therapy Services, LLC, herein not to exceed the facilities regular charges for this treatment.

\_\_\_\_\_ SELF PAY: It is our policy that you will be treated fairly and with respect regardless of your ability to pay for the services you receive. If you don’t qualify for local health assist programs, you will be offered a prompt pay discount. We also provided reasonable, interest-free payment arrangements.

Certified Hand Therapy Services reserves the right to seek reimbursement from all your insurers regardless if you provide us with their contact information, unless you instruct us to bill you directly. All records released require an administrative and copying fee paid to Certified Hand Therapy Services before they are released, regardless of requestor. Certified Hand Therapy is HIPAA compliant in regard to information sharing polices.

By signing this document, I acknowledge that I have read, understand, and agree that the information contained in this document including insurance benefits and any additional information I have presented to verify my own identity including my state issued driver’s license, state issued photo identification, or my passport, and if applicable, any information used to verify the identity of a minor beneficiary is current, correct, and complete to the best of my knowledge. I agree to the financial terms stated above.

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Signature of Patient or Responsible Party Date