Statement of Financial Responsibility

Patient Name: _____ Date of Birth: _____

Thank you for choosing Rehabilitation Consultants, Inc. as your provider for Physical Therapy. We are committed to providing you with the best possible service and ask that you read and acknowledge the terms of our financial policy.

As a courtesy, our office does contact your insurance company to verify your benefits and obtain authorization prior to your first visit with us. We are just simply relaying the information provided to us from your insurance company. It is ultimately the **PATIENT'S RESPONSIBILITY** to understand your insurance company's benefits. If your benefits differ than what you expected, there could be significant out-of-pocket expenses.

If you have a plan with a co-insurance percentage or deductible which has not been met, we will estimate the co-insurance/deductible amounts based on what we have been lead to expect by your insurance company. Please note any payment made on the date of service is considered a deposit towards your estimated patient balance. Since this is an estimate, there is always the possibility that you may be either responsible for an additional balance.

**** I Have Read and Understand the Paragraph Above. Please Initial Here _____**

Rehabilitation Consultants, Inc. cannot assume responsibility for incorrect information provided to us concerning your insurance policy. Our courtesy verification of eligibility and benefits does not guarantee that your insurance company will pay for all services provided. Your insurance policy is a contract between you and your insurance company. You are responsible for knowing your level of coverage and are ultimately responsible for the full payment of your bill.

To help us in determining the number of visits remaining on your plan, please let us know if you had any of the following services during this current year:

1) **Chiropractic Services** # of visits: _____

2) **Home Health Care** # of visits: _____

3) **Physical Therapy at Another Facility** # of visits: _____

4) **Occupational/ Speech Therapy** # of visits: _____

**** I Have Entered Above Information to Best of My Knowledge. Please Initial Here _____**

BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this section.

I authorize Rehabilitation Consultants, Inc. to disclose my health information that is directly related to my current treatment at Rehabilitation Consultants, Inc. to the individual(s) listed below for purposes of their role in my treatment or payment for the health services.

Such persons involved in your care may include: spouse, children, blood relatives, roommates, boyfriends/girlfriends, domestic partners, neighbors, and colleagues.

NAME	RELATIONSHIP

I don't wish to have my health information disclosed to these individuals involved in my care

NAME	RELATIONSHIP

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Rehabilitation Consultants, Inc. through its appropriate personnel, to furnish medical care and treatment to me, or the above named patient, considered necessary and proper in diagnosing or treating my/his/her physical condition.

Signature: _____ (self - guardian - other: _____) **Date**: _____

I further authorize Rehabilitation Consultants, Inc. to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

Signature: _____ (self - guardian - other: _____) **Date**: _____