ASSIGNMENT OF BENEFITS

I hereby assign benefits to include major medical benefits, private insurance and any other plan to Physical Therapy Center of Rocky Hill. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges not covered or not paid by said insurance at the time of service. I hereby authorize said assignee to release all information necessary for payment purposes.

Note: Any estimates of benefits disclosed to us by the insurance representative are merely estimated coverage information we obtain, and are in no way intended to release the patient from total responsibility for their account or be implied as guarantee of payment by the insurance carrier. The patient will be financially responsible for all charges not covered or not paid by said insurance.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

If I am covered by an insurance plan that requires a referral and I do not obtain one from my Primary Care Physician or specialist, I will be responsible if my insurance carrier does not pay the claim. This statement also applies to future visits if the referral has expired or additional visits need to be authorized.

I am responsible to keep track of my referral. I will be sure to keep a copy of the referral or call my insurance carrier and confirm that a referral was received from my Primary Care Physician or specialist.

If I am being treated for a work-related injury, I am required to comply with the referral policy of my employer's insurance plan.

ATTENDANCE POLICY

I understand that good attendance is essential to receive the most benefit from my therapy program.

I will inform Physical Therapy Center of Rocky Hill if I am unable to keep my appointment and give 24 hours notice, if possible. I understand that PTC will make every effort to reschedule my appointment. If I am late for an appointment I understand the therapist will see me as the schedule permits.

****I understand that failure to keep my appointments and give 24 hours' notice may result in $25.00 fee and that the therapist might discuss this with my doctor which may then result in discharge. ****

CONSENT FOR TREATMENT

I hereby give Physical Therapy Center of Rocky Hill my consent for any necessary medical evaluation and treatment.

****

I have read and understand all above policies and I agree to them. I understand, per my insurance contract, I am financially responsible for any charges not paid by my insurance carrier.

X_____

Patient/Legal Representative Signature ***Date***

If signed by the Legal Representative, indicate your relationship to the patient below:

Parent Guardian Conservator* Executor of Estate* Power of Attorney*

Other**_____

Witness Signature (if Legal Representative signs) ***Date***

*Must be accompanied by supporting documentation **Must be explained; subject to approval