CAMELVIEW PHYSICAL THERAPY, INC

ASSIGNMENT OF BENEFITS FOR MEDICAL PAYMENT OF SERVICES/ ACKNOWLEDGMENT OF OFFICE POLICIES

Authorization for Release of Information: I authorize Camelview Physical therapy, Inc. to disclose all or any part(s) of my medical record to listed insurance companies and any agency conducting reviews concerning Workman's Compensation care.

Medicare Certification: I certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act is correct. I request payment be made directly to the provider of services on my behalf and I authorize said provider to release any and all information necessary regarding the treatment and services provided as stated below.

Assignment of Benefits: I hereby authorize payment directly to Camelview Physical Therapy, Inc by my insurance company(s). In the event an overpayment is made from more than one insurance company, I understand the overpayment will be sent to the appropriate payer. In the event I receive payment from my insurance company for services at Camelview Physical Therapy, Inc, I will surrender the payment to Camelview Physical Therapy, Inc.

Insurance: Camelview Physical Therapy, Inc. will submit your insurance claim as a service to you. If our office does not hear from your insurance company within 60 days, we request your help in contacting your insurance company to resolve the payment delay. **I understand my insurance plan is a contract between me and my insurance company, and Camelview Physical Therapy, Inc must hold me responsible for any balances due.**

Payment of Services: I understand that I am financially responsible for all charges and fees related to my care. I further understand that payment in full is expected upon receipt of the first statement which may include copayments, deductibles, and any service not covered by insurance plan. In the event my account is referred to a collection agency, I will be responsible for collection costs, including interest and reasonable attorney fees.

Health Insurance Portability and Accountability Act (HIPAA): I acknowledge that a copy of the HIPAA notice of privacy practices was available to me.

Valuables: I understand that Camelview Physical Therapy, Inc. is not responsible for valuables and personal property brought to the facility.

Medical Release Forms: I understand that information within my medical record is protected by law and the physical therapists and staff of Camelview Physical Therapy, Inc. **WILL NOT** disclose any information to outside entities without written consent, this includes my spouse and family members. I also understand that any signed medical release forms are good for one year unless otherwise noted and therefore must be updated appropriately.

Personal Information: I understand that it is my sole responsibility to notify Camelview Physical Therapy, Inc. of any change in my address, contact numbers, insurance plans, etc.

No Show and Cancellation Policy: Although Camelview Physical Therapy, Inc. understands that situations may arise that can lead me to cancel my appointment, I understand that Camelview Physical Therapy, Inc. requests a 24 hour notice for cancellations so that my appointment may be offered to another patient. I further acknowledge that Camelview Physical Therapy, Inc. reserves the right to charge a "no show" fee in the event that I do not call and cancel my scheduled appointment.

Treatment: I understand that I am responsible for facilitation of my care and that it is expected that I will be compliant with my treatment plan.

I certify I have read and fully understand all of the above information to include the consent for treatment, release of information, insurance authorization and assignment and payment of services

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Patient of Responsible Party Signature Date