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. I fully understand that I am directly and fully responsible to Camelview Physical Therapy for all medical bills submitted for services rendered to me. I understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee. 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 or Responsible Party Signature Date