

## TO ALL INSURANCE PATIENTS

The policy of this facility is to work with each patient and their insurance carrier to insure that the patient receives the therapy they need and the facility is reimbursed for these services. Our goal is to assist the patient as much as possible by providing the courtesy of billing the insurance carrier for reimbursement. Please be aware that the patient is still responsible for the co-payment and/or % that the insurance carrier does not reimburse, and any deductibles, under the terms of your policy. If we are to continue to provide this courtesy to all of our patients, we need everyone's cooperation. Also, if you receive the insurance check for our services, we need to receive the payment mailed to you by your insurance carrier within 30 days.

**\*\*\*\*PATIENTS WITH HMO/PPO CO-PAYMENTS ARE RESPONSIBLE FOR MAKING CO-PAYMENT AT THE TIME OF EACH TREATMENT\*\*\*\***

I hereby consent to treatment at Englewood Cliffs Physical Therapy and to be treated by anyone affiliated with Englewood Cliffs Physical Therapy. I am aware that all of my medical records are privileged and I demand that none of my records be disclosed to any person, insurance company or agency without my written consent.

I am aware that any balances outstanding after 90 days of billing will be charged one percent per month on the outstanding balance, until the bill is paid. I am aware that I will be responsible for any and all costs and fees (including all reasonable attorney fees, expenses and court costs) incurred by Englewood Cliffs Physical Therapy in collecting any outstanding amount of my bill. I further agree to have all controversies arising from this agreement litigated in the county in which this contract is signed. I acknowledge that outcomes of treatments can vary, and that I have been given no implied or expressed guarantees about my treatment. I have also been given the opportunity to ask questions about the cost of initial visit, testing and /or treatment, and that I am the primary guarantor of all costs incurred in my treatment

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I understand that I am fully responsible for the deductible, co-payment or any balance that the insurance states as my responsibility. A photocopy of this assignment shall be considered as effective and valid as the original.

- If payment by workers compensation or no fault is denied for any reason, I will assume full responsibility for payment of professional services rendered by Englewood Cliffs Physical Therapy & Sports Med.
- I hereby consent to allow my son/daughter, if under the age of 18, to attend therapy without the presence of a parent or guardian.
- I understand that there may be a \$25 fee if I do not cancel within 24 hours of my appointment. I understand that I will be billed at the end of every month for my co-payments if they have not been paid in full at the time of treatment.

I hereby instruct and direct \_\_\_\_\_ Insurance Company to pay by check made out and mailed to ENGLEWOOD CLIFFS PHYSICAL THERAPY, 701 Palisade Avenue, Englewood Cliffs, NJ 07632.

Signature of Claimant \_\_\_\_\_ Date: \_\_\_\_\_