Financial Responsibility Policy

Patient Name:____ Date:___________________

Financial Responsibility

I certify that the information provided to Performance Rehab Clinic (PRC) is true to the best of my knowledge and belief. In consideration of the physical therapy services and/or treatments rendered to the above named patient. I assume responsibility for and guarantee the payment of all service and/or treatment charges in accordance with the practice's then current rates. The patient portion of all charges is due and owing at the time services and/or treatment is rendered. The legal judicial interest rate will be added to all unpaid balances which are more than thirty (30) days delinquent. I also agree that, except as provided by law, I shall be responsible for the payment of any services and/or treatment charges which for any reason are not paid by any payer or insurance company. I also authorize PRC to initiate a complaint to the Insurance Commissioner on my behalf. In the event this account it rendered delinquent and is placed in the hands of an attorney or collection agency for collection and/or resolution of account disputes, regardless whether formal legal action is instituted. I agree to pay, in addition to the principal amount due and owing, a fee of forty (40%) percent of the principal amount as well as all costs incurred in connection with said collection. I acknowledge that in addition to the face amount of the check, additional fines, fees and penalties will apply to all NSF and/or stop payment check as provide by law, including but not limited to a $25.00 service charge and agree to pay such prior to the rendering of further physical therapy services and/or treatments.

Cancellations

Cancellations of scheduled appointments must me made not less than 24 hours in advance of the scheduled appointment time. I acknowledge and agree that failure to provide timely notice of cancellation will result in the assessment of a $25.00 office fee payable by me, not payable by me insurance company, which fee is due and owing prior to the rendering further physical therapy services and/or treatment.

Contest for Treatment

I hereby authorize Performance Rehab Clinic 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 the physical condition. I agree and consent to all procedures and medical services and/or treatments deemed necessary by PRC and/or the patient's physical therapist. I acknowledge that all information provide is made in the best professional judgment of PRC and being mindful of the uncertain nature of complications that there is o guarantee expressed or implied, as to the success or other results of the physical therapy services and/or treatments rendered.

Medical Release and Assignment of Insurance Benefits

I authorize PRC to release all medical records, billing information and/or protected health information, which may be of a sensitive nature to the Social Security Administration, health maintenance organizations, worker's compensation carriers, employers, or persons acting on behalf of a preferred provider arrangement (or any of their agents ore representatives) when such information is requested for payment, utilization review or coverage determination purposes. I understand that this authorization is strictly voluntary, that I may refuse to consent to such and my revoke such consent at anytime, except in instances where a particular action depends upon the consent remaining in effect, including but not limited to securing full payment of the account. The authorization to release medical information herein contained shall also apply to all physical therapists employed by and/or contracted through PRC. I further authorize any such payor or insurance company to pay directly to PRC all benefits due and payable as a result of physical therapy services and/or treatment by PRC.I hereby assign PRC all benefits due me for physical therapy services and/or treatments under any applicable policy of insurance. I accept the financial responsibility to PRC for all charges not paid by any payor or insurance company and hereby promise to pay within thirty (30) days of the date of service and/or treatment any remaining balance.

I have read this document and agree to the information printed above and understand that I may receive a copy upon request.

____ ___________________________

Signature of patient or legal guardian Date

____ ___________________________

Relationship to patient Witness