

PATIENT CONSENT FOR TREATMENT AND PAYMENT POLICY:

I consent or am signing for the minor named on this form to be examined and treated by BrownStone Physical Therapy or a representative thereof. Please initial: _____

I consent to have BrownStone Physical Therapy disclose my protected health information for payment, treatment and healthcare operations, and for such other purposes that are permitted under HIPPA regulations without written authorization. Please initial: _____

I understand and agree that (regardless of my insurance status); I am ultimately responsible for any balances on my account for professional services rendered. I request that payment of authorized benefits be made to BrownStone Physical Therapy for any services furnished to the so names minor or me by the providers of BrownStone Physical Therapy. Please initial: _____

I authorize any holder of medical information about me to release to any appropriate insurance company and its agent's information needed to determine these benefits payable for related services.
Please initial: _____

I understand that by accompanying and signing for the so named minor I am assuming responsibility for payment of any costs involving the care or treatment of the so named minor. Please initial: _____

I understand that if my insurance company requires a co-payment, the co-payment is my responsibility and is due at the time of service. Please initial: _____

I understand that it is important that I know and understand what my insurance company covers and that my insurance company is expected to pay or deny my claim within 30 days. If my claim is not paid within 60 days, I understand that the balance due will be transferred to my personal account balance and it will be my responsibility to contact the insurance company regarding the non-payment of the claim. My insurance policy is a contract between my insurance company and me and it is understood that BrownStone Physical Therapy is not a party to that contract. Please initial: _____

The Health Insurance Portability and Accounting Act (HIPAA) is the result of efforts by the Clinton Administration and Congressional healthcare reform proponents to reform healthcare.

In essence the legislation was formed to protect you as a patient by reducing healthcare fraud and abuse, to enforce standards for health information and the way in which your professional health information is handled and to guarantee security and privacy of your health information.

Legislation has mandated that HIPAA compliance be in effect as of April 14, 2003.

Receipt of privacy notice: Please initial: _____

Forms of payment accepted: Cash or check

By my initial after each statement, I understand and agree to accept.

Patient Name (PRINTED)

Date

Patient/Parent/Guardian Signature

Relationship

Disclaimer: Failure to sign this form will discontinue submission of claims(s) to appropriate insurance company and patient will be responsible for payment at time of service.