



Patient's Certification, Authorization to Release Information and Payment Request

RELEASE OF MEDICAL INFORMATION

I hereby authorize the release of any necessary and pertinent information to my insurance company of their representative for the payment of my insurance claim for Physical Therapy Services rendered at Excel Physical Therapy.

ASSIGNMENT OF BENEFITS

I authorize my insurance carrier to pay the claim for Physical Therapy Services directly to the provider, namely Cocksackie Physical Therapy Associates, W. Cocksackie, NY 12192.

I authorize release of any information needed to act on this request, I request that payment of authorized benefits be made of my behalf.

AGREEMENT FOR PAYMENT AND CO-PAYMENT

I understand that Excel Physical Therapy will make every effort to obtain as much reimbursement as possible from my insurance company, but if I do not provide an In-Plan referral form where needed, or if for some reason Excel Physical Therapy is unable to collect reimbursement from my insurance company(ies), I agree to be financially responsible for any portion of the bill for my physical therapy services that is not covered.

I, _____, understand that most insurance companies utilize co-payments or co-insurances as part of their plans and that these payments are **per visit**. I also understand that it is **my responsibility** to be aware of the specifics of my insurance plan and the portions of billed services for which I am responsible. I further understand that co-payments are due at the time of visit and that failure to pay can lead to (including but not limited to) my account being sent to collections, credit bureau reporting or legal action. I understand that Excel Physical Therapy will, to the best of its ability follow the policies for patient payments set out by contracted agreements between third party payers and patients receiving services. I agree to promptly inform Excel of any changes in my insurance plan to allow accurate billing for services.

Current co-payment amount (if applicable) _____

I, _____, have read all of the above, release of medical information, assignment of benefits, agreement for payment and the agreement for co-payment and understand my responsibilities inherent in each.

Signature: _____

Date: _____

PATIENT'S RIGHTS AND PRIVACY ACT NOTICE

I have received a paper copy of this notice.

Signature: _____

Print Name: _____

Date: _____

I make the following special request for confidential communications: _____

Signature: _____

Date: _____