ROCKLAND PHYSICAL THERAPY

ASSIGNMENT OF BENEFITS, PAYMENT RESPONSIBILITY AND AUTHORIZATION FOR TREATMENT/RELEASE OF INFORMATION

PATIENT: _____ ("Patient") CLINIC: Rockland Physical Therapy

1. THE UNDERSIGNED hereby authorizes ROCKLAND PHYSICAL THERAPY ("Provider") to render any and all therapy services (Physical Therapy, Occupational Therapy, Speech Therapy, Social Services if indicated), or other related services that Provider feels are necessary or advisable to the patient in conjunction with physician referral. The patient shall cooperate with all reasonable requests by Provider in connection with Provider's rendition of therapy and related services.

2. Provider will not condition my treatment, payment, or eligibility for benefits on whether I provide authorization for the requested use or disclosure of information pertaining to my treatment or condition. Further, I understand (i) that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights) and (ii) that I have the right to refuse to sign this authorization

3. I certify that the information given by me in applying for payment under my insurance contract is correct. I authorize any holder of medical or other information about myself, be released to Provider any information needed for this or a related claim. I request that payment of authorized benefits be made on my behalf for services rendered by Provider. I understand that this request is effective until revoked, and I agree to pay any co-payment or deductible that is my responsibility under my insurance entity. I permit a copy of this signature to be used in place of the original.

4. In the event that I receive payment from my insurance company for services rendered by Rockland Physical Therapy, I agree to endorse that check to Rockland Physical Therapy and deliver it to them. I understand that I should not keep that money.

5. In the event services are not covered by my insurance contract, I agree to pay Provider for all therapy services rendered and I attest that I have been notified of said charges.

6. I hereby authorize Provider to furnish any and all information with respect to any illness or injury, medical history, consultation, prescriptions, or treatment, and copies of all medical records upon written request to the insurance contractor. A Photostat copy of this authorization shall be considered as effective and valid as the original. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the Provider and may no longer be protected by federal or state law.

7. THE UNDERSIGNED, and Patient agree to execute any documents and perform any acts that Provider may reasonably request. The undersigned warrant and represent that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of patient.

8. THE UNDERSIGNED, agree that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; provided, however, that the provisions of paragraphs 2 and 3 shall survive any such termination.

9. THE UNDERSIGNED, acknowledge that the Provider has disclosed to the undersigned that no physician owns any interest in Provider.

10. THE UNDERSIGNED, understands that they have a choice of rehabilitation service providers.

_____ _____

Patient's Signature/Legal Representative **Date** **Witness** **Date**

_____ _____

Financially Responsible Party (if under the age of 18) **Date**

2 Executive Boulevard Suite 204A, Suffern, NY 10901 ○ Tel 845-357-5686 Fax 845-357-3897