Specialists in Rehabilitation Medicine, PC
2018 Authorization Statement

Patient Name: _____

I authorize treatment by Specialists in Rehabilitation Medicine, P.C.

I authorize the release of any necessary medical information to my insurance carrier that is required for determination of payment for the medical services rendered.

I authorize the release of medical information to other medical doctors or health care providers involved in my healthcare.

All co-pays, deductibles, and unpaid balances are due at time of visit or by date of statement. Should Specialists in Rehabilitation Medicine, P.C. not be participating with my carrier, I agree to pay the difference over and above the allowed amount for services rendered. Your insurance may deny claims for a variety of reasons, which include:

1. The services provided may not be a benefit of your health insurance policy or may not be covered when provided by our office.
2. You may have exhausted your benefit for the services provided.
3. MEDICAL NECESSITY or MEDICALLY NECESSARY generally means a determination based upon the criteria and guidelines developed by your insurance carrier in consideration of generally accepted standards and practices.
4. You may have failed to pay your premium and are in the final 60 days of your grace period.

I understand that I am responsible for knowing the limitations of my insurance coverage. As a courtesy, Specialists in Rehabilitation Medicine P.C. will attempt to verify your coverage and estimate the patient's financial responsibility. This is not a guarantee of insurance payment or an exact balance owed for your services.

I understand a statement of my charges will be sent to my mailing address unless I otherwise indicate.

Fees

A $25.00 fee may be added to your account balance for the following circumstances:

- Returned checks
- "No Call, No Show" as well as for appointments that are cancelled less than 24hrs prior to my appointment.
- Balances that are sent to an outside collection agency due to delinquency. Past due balances that remain unpaid past 120 days are subject to being placed with an outside collection agency. It is my responsibility to establish payment arrangements with the billing office if I am unable to pay my balance in full at the time of service or upon receipt of my first statement.

Punctuality/Attendance

I understand that if I arrive more than 20 minutes late to my appointment, I may be asked to reschedule my appointment.

I understand that having 3 missed appointments or late cancellations (less than 24 hour notice) will result in Discharge from the practice.

Signature of Patient/Responsible Party: _____ Date:_____

Signature of Witness _____

MEDICARE PATIENTS ONLY

I hereby authorize the release of any information acquired in the course of my examination of treatment to the Center's for Medicare & Medicaid Services and its agents for services rendered by Specialists in Rehabilitation Medicine P.C. I request payment be made directly to the provider of care.

In addition, I understand that if I request services and am informed that Medicare may not cover, I will sign an ABN form and understand that by doing so, I will be responsible for paying the difference

Signed:_____ Date:_____