1315 S. Hawthorne Rd. Winston-Salem, NC 27103
5380 US HWY 158 Ste. 205 Advance, NC 27006

STATEMENT OF FINANCIAL RESPONSIBILITY & AUTHORIZATION FOR OUTPATIENT THERAPY

FINANCIAL RESPONSIBILITY

In consideration for outpatient therapy services rendered or to the Patient named herein, we the undersigned agree(s) to pay all therapy charges for services, supplies and incidentals furnished by Aware Physical Therapy to or for the benefit of the Patient. Payment is due in full within 30 days of services. In the events of nonpayment, the undersigned guarantees payment of any late charges assessed by Aware Physical Therapy and all costs of collections, including reasonable attorney's fees. I authorized the transfer of monies paid to Aware Physical Therapy by or on behalf of the Patient and otherwise refundable to the Patient or Guarantor, to other accounts at Aware Physical Therapy for which the Patient or Guarantor is responsible.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment of medical benefits payable to me, directly to Aware Physical Therapy. I understand that billing of insurance is a service only and not guarantee of payment. I am also responsible for payment if my insurance carrier decides this is a non-covered service or requires prior authorization that I did not obtain. I understand that I may choose to continue services that are not covered by the Patient's insurance carrier at my own expense so long as Aware Physical Therapy has notified me in advance that the insurance carrier may not cover or continue to cover all services.

MANAGED CARE

I certify that I am responsible for the terms of enrollment, which may be part of my insurance plan. I understand that if my insurance does not pay because of misrepresentation/non-compliance with terms of my policy, I am responsible for the charges not covered by my insurance. Payment must be made in full within 30 days unless payment arrangement is made in advance.

MEDICARE-MEDICAID CERTIFICATION

I certify that the information given in applying for payment under Titles XVII and XIX of the Social Security Act is correct. The office is hereby authorized to release all records required to act on this request. I (We) request that payment of authorized benefits is made on Patient's behalf.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I understand that I may revoke or amend the following authorizations at any time except to the extent that actions have already been taken: RELEASE FOR PAYMENT PURPOSE: I authorize Aware Physical Therapy and the treating therapists to furnish any information relating to this treatment to representatives of any party financially responsible for the Patient's care or to any governmental or charitable agencies. RELEASE OF TREATMENT/QUALITY REVIEW PURPOSE: I authorize Aware Physical Therapy to allow the treating therapists and office personnel access to the Patient's medical record as needed to provide healthcare services to the patient or to perform quality reviews. I authorize release of medical information about the patient to the referring physician to whom the patient may be referred.

AUTHORIZATION FOR TREATMENT

I hereby consent to the outpatient therapy treatment to Aware Physical Therapy and give permission to Aware Physical Therapy to provide the services deemed necessary in the diagnosis and treatment of this patient. I am aware and acknowledge that no guarantees have been made as to the result of treatment or examination in this facility. I understand that the patient has the right to withhold consent to a medical service that is deemed necessary or advisable by the therapists.

CANCELLATION POLICY

I understand that in the event of a cancellation it is the patient's responsibility to notify the clinic within 24 hours. Failing to do so without proper notice will result in a $25.00 No-Show Fee. This charge will not be covered by insurance and will be paid by the patient personally.

NOTICE OF PRIVACY

Aware Physical Therapy has Notice of Privacy that states how we may use your health information. Notice of Privacy is displayed in the clinic, but a copy is available upon request. Please let us know if you have questions about this notice. By signing below, you (or your legal representative) agree that you have been offered the opportunity to review our Notice of Privacy and understand its terms.

MY SIGNATURE BELOW INDICATED APPROVAL OF THE ABOVE UNLESS OTHERWISE INDICATED

_____ (Seal) Date: _____
Patient Signature

_____ (Seal) Date: _____
Responsible Party/ Guarantor