Insurance Information and Financial Agreement

I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself; and I am ultimately responsible for understanding what my policy covers and does not cover. I understand that CORE Rehabilitation will bill my insurance carrier directly and prepare any necessary reports and forms to file claims.

Any amount authorized to be paid to CORE Rehabilitation will be credited to my account upon receipt. However, I clearly understand that I am personally responsible for payment regarding services rendered at this office if my insurance does not cover it. I also understand that every attempt will be made by CORE Rehabilitation to notify me of the coverage of my insurance.

I hereby authorize CORE Rehabilitation to:

- Release and/or receive any medical information necessary to Insurance Carriers and/or Medical Doctors regarding my medical condition and treatment.
- To process insurance claims generated in the course of the examination and/or treatment.
- To receive payment to the undersigned provider for services rendered.

I further understand that fees such as co-payment, co-insurance and/or deductible are due and payable on the date services are rendered, and I agree to pay all such charges in full. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all additional costs CORE Rehabilitation endures during the attempt to collect such fees. I also understand that I may be charged a $35 fee on all returned checks.

Acknowledgement of Privacy Practice Notice

I understand that CORE Rehabilitation (referred to below as “the clinic”) will use and disclose health information about me in the course of providing physical therapy care to me. I understand that the clinic is permitted to use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult and coordinate with other health care providers in the course of my treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- Perform various office, administrative and business functions that support the clinic’s ability to provide me with appropriate care and arrange for payment.

By signing below, I agree that I have reviewed and understand the information above and agree to the terms and conditions presented to me by CORE Rehabilitation.

Printed name: _____

Patient’s signature: _____ Date: _____
(Parent/Guardian if patient is under 18 years of age)