Synergy Rehab, OT LLC: Patient Consent

Consent to Treatment:

I _____ consent to treatment and services to be provided by Synergy Rehab, OT LLC including physical therapy, occupational therapy, and speech therapy.

Disclosure of Protected Health Information:
I understand that my personal health information is protected by federal regulations under the Health Information Portability and Accountability Act (HIPAA) and may not be disclosed without my authorization and consent.

I understand that my protected health information will and may be used for purposes of treatment, payment, and healthcare operations. I understand that I have the right to request a restriction in how my protected health information is used and disclosed. I may obtain a copy of the notice of privacy practices by contacting the office.

Referral & Authorization Policy:
To assist you, as a courtesy, Synergy Rehab, OT LLC will verify your insurance benefits and bill your insurance carrier on your behalf. However, it is your responsibility to check your benefits and coverage with your insurance carrier. If your insurance carrier requires an authorization for service, services may/will be delayed at the discretion of Synergy Rehab, OT LLC until the authorization is obtained. Furthermore, we may be required to contact your doctor for a treatment order/referral for services.

Statement on Financial Responsibility:

I _____authorize payment of my Medicare and/or Insurance benefits to be made directly to Synergy Rehab, OT LLC on my behalf for services rendered. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me, I will endorse such payments to Synergy Rehab, OT LLC within five (5) days of receipt of such payment. I hereby give Synergy Rehab, OT LLC a consent of financial responsibility implying that I will be responsible for payment in full of co-payments / co-insurances / deductibles / any additional stipulations regarding my coverage determined by my insurance carrier / any amount not covered by my insurance / remaining balance of partially covered claims. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I further understand, Synergy Rehab, OT LLC will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I have read and understand the above policy. I agree to pay Synergy Rehab, OT LLC the full and entire amount of the bills incurred by me or the above named patient, if applicable, any amount due after

payment has been made by my insurance carrier. I understand I am financially responsible to Synergy Rehab, OT LLC for charges not covered by this authorization.

Policy Regarding Medicare:
Synergy Rehab, OT LLC is a participating provider of Medicare; and will handle all billing to Medicare as well as any secondary insurance. Medicare requires you to satisfy a yearly deductible before they will begin paying benefits. Medicare will deduct the deductible amount from the first claim they receive each calendar year. Unless you have satisfied your annual deductible with another Medicare provider's office you are responsible to pay your deductible to Synergy Rehab, OT LLC. After your deductible is satisfied Medicare will reimburse us 80% of their standard fee for Therapy services that are deemed "medically and reasonably necessary". Therefore your payment responsibility is 20% of the standard Medicare fee for service. Some secondary insurance providers may cover the remaining 20% which can be determined prior to starting services.

Statement on Medicare Financial Responsibility:
Medicare may find that therapy services are not "reasonable and/or medically necessary" for the illness, injury or condition for which I am seeking treatment. I understand that Medicare bases this ruling on the diagnosis provided by my physician and their standards for that diagnosis. I understand, in this case, I will be responsible for any and all charges incurred.

Cancellation Policy:
I agree to provide at least 24hrs notice prior to canceling or rescheduling services. Synergy Rehab, OT LLC will make every effort to reschedule an appointment at the clinician's availability, however a cancellation/reschedule of less than 24hrs notice may result in a cancellation fee of $50.

Credit Card Authorization Agreement:
I agree to provide payment for services rendered on the date of services provided, billable to the card provided on file to Synergy Rehab, OT LLC. I understand that it is my responsibility to provide written notice to Synergy Rehab, OT LLC to discontinue use of authorized payment sources and provide an alternate payment source as desired.

I certify that I have read, understand, and fully agree to each of the statements.

_____ _____
Signature of Patient or Legally Responsible Person Date

_____ _____
Printed Name of Above (& Relationship) Date