Ray Burns, PT Rehab Movement Wellness, LLC

Release of Information/Consent of care/assignment of benefits

Name_____Date_____

- I acknowledge that the insurance information given by me to Ray Burns in applying for payment from insurance(s) is correct. I request that payment of authorized benefits be made on my behalf to Ray Burns/Rehab Movement Wellness, LLC. If applicable, I am responsible for updating my insurance companies with coordination of benefits. In the event that I receive direct payment of benefits, I agree to remit such funds to Rehab Movement Wellness, LLC. I agree to pay co-pay, co-insurances or deductibles required by insurance/health plans. I agree to pay for physical therapy services not covered by insurance/health plans to the extent legally allowable. Should my insurance company refuse payment by deciding to dispute the fees or question "medical necessity" of physical therapy treatment, I shall take full responsibility for payment of any and all outstanding balances. I am responsible for all fees incurred to collect debt. I consent to receiving physical therapy services.

- Acknowledgement receipt. If requested, I the undersigned have received a copy of the "Notice of Privacy Practices" as in accordance with the Health Insurance Portability and Accountability Act (HIPPA).

- No show fee-$30 no show fee will be charged to you for each missed appointment. You are encouraged to be on time for your appointments. If you are 15 minutes or more late for a scheduled appointment, you will be considered a NO SHOW and the $30 will apply. Appointments must be cancelled with 24 hours notice to avoid the $30 no show fee. Exceptions freezing rain or unstable medical condition discussed at evaluation.

Signature_____Date_____
Patient

Signature_____Date_____
Authorized representative