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__ Katz JCC, 1301 Springdale Rd • Cherry Hill, NJ 08003 • 856.424.4444 • Fax: 856.673.2589

__ New Albany Professional Bldg, 2800 Rt. 130 North, Ste 104 • Cinnaminson, NJ 08077 • 856.829.0499 • Fax: 856.829.1899

ASSIGNMENT OF BENEFITS

I authorize payment of Medicare/Insurance benefits to be made directly to Rehab Connection on my behalf for physical/occupational therapy services rendered. I also authorize Rehab Connection to release my protected health information for treatment and billing purposes. Initials _____

NOTICE OF PRIVACY PRACTICES

I have received a written copy of Rehab Connection’s Notice of Privacy Practices. The notice provides, in detail, the uses and disclosures of my protected health information that may be made by Rehab Connection, my rights as the patient, and Rehab Connection’s legal duties with respect to my protected health information. Initials _____

FINANCIAL POLICY

As a courtesy, Rehab Connection will pre-verify your insurance benefits. Please note: Unless you have secondary insurance, all co-pays, deductibles, and/or co-insurance is the patient’s/guardian’s (in case of a minor) responsibility. Co-pays are due at the time services are rendered. Your deductible/co-insurance will be billed to you once we have received an “Explanation of Benefits” from your insurance carrier.

Balances older than 60 days will accrue interest at a rate of 3% per month. There is a \$25 fee for returned checks. Collection and billing fees will be charged to any account billed multiple times.

*Payment methods include: cash, check, money order, Visa, MasterCard, and Discover. Initials _____

MEDICARE PATIENTS

I have been informed of the Medicare cap for outpatient therapy services. Initials _____

CANCELLATION/NO-SHOW POLICY

Rehab Connection urges you to keep every appointment, as consistent treatment will increase a speedy recovery. We require 24 hours notice if you need to cancel an appointment. Patients who cancel without proper notice or fail to show up for scheduled appointments will be subject to \$25 charge. Initials _____

SIGNATURE ON FILE

I have read and understand the above policies and procedures.

Patient’s/Guardian Signature

Date

Reviewed By

Date