I also understand the doctor is unable to determine the amount of time it may take my insurance company to pay for services rendered. I understand, however, that in general, most insurance companies will pay for services rendered within 30 days. If my insurance company has not paid for the charges in full within 90 (ninety) days of a specific visit, I understand that I will be responsible for any and all costs, fees and attorney's fees associated with collection thereof.

I understand that if I am currently or during the course of my treatment with the Practice become enrolled with a Home Health Agency, Medicare will likely not pay for the Practice's services. I understand this and agree to be financially responsible for all monies due and owing the Practice for their services.

I assign my insurance benefits to the Practice. I understand this form is valid for one year unless I cancel the authorization through written notice to the healthcare provider.

By signing this form, I am consenting to the Practice's use and disclosure of my PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information.

By Signing this form, I am further consenting to the assignment of my insurance benefits to the Practice.

I understand that I may revoke my consent in writing, except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that the Practice may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____ _____
Phone Number(s) (Cell/Home/Work) Email Address

Enrolled in Home Health Agency: ___Yes ___No

AT HOME ACTIVE MOTION PHYSICAL THERAPY SERVICES P.C.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby consent to At Home Active Motion Physical Therapy Services P.C. (the "Practice") using and disclosing my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I hereby acknowledge that I have had the right to review the Practice's Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that the Practice reserves the right to revise its Privacy Policy at anytime. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request for same to the Practice.

I hereby specifically consent to the Practice disclosing my PHI to and communicating about my PHI with my primary care physician, consulting physicians, other medical or healthcare providers as well as members of my family and designated representatives.

I hereby specifically consent to the Practice disclosing my PHI to and communicating about my PHI with the Centers for Medicare and Medicaid Services (CMS) and other payors for purposes of payment.

Consent to Calls/Mail/Email

I hereby consent to the Practice calling my home, cell phone or other designated location and leaving a message on my voicemail or in-person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment.

I hereby consent to the Practice mailing to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I hereby consent to the Practice e-mailing me any items or communications that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements.

I understand that I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Assignment of Benefits

I understand that I am financially responsible for my bill for services rendered in this office. Should this bill be sent to my insurance company for my convenience, I understand that I still remain obligated to pay the entire balance, no matter what my insurance company pays. I understand that the insurance company may not cover certain services and may also not cover a deductible, copayments and other charges. I also understand that the insurance company may also determine that certain charges were "unnecessary." This does not mean that they were medically unnecessary, but that it was unnecessary for the insurance company to pay for them.