REHABILITATION ASSOCIATES, INC.

☐ 1931 Black Rock Tpke
Fairfield, CT 06825
(203) 384-8681
(203) 384-0722 FAX

☐ 2900 Main Street
Stratford, CT 06614
(203) 378-0092
(203) 375-4540 FAX

☐ 555 Bridgeport Ave
Shelton, CT 06484
(203) 922-1773
(203) 924-2334 FAX

☐ 680 Boston Post Rd
Milford, CT 06460
(203) 783-1997
(203) 783-3997 FAX

☐ 728 Post Road East
Westport, CT 06880
(203) 341-0488
(203) 227-8809 FAX

FINANCIAL POLICY AUTHORIZATION AND AGREEMENT

1. a. ASSIGNMENT OF BENEFITS: I hereby authorize payment of medical benefits to Rehabilitation Associates, Inc. and certify that all sums assigned, including Automobile Personal Insurance Protection, be sent directly to Rehabilitation Associates, Inc. In the event my insurance company does not honor this request, I take responsibility for payment of my bill in full. As a courtesy, Rehabilitation Associates, Inc. assists with insurance benefit verification, however, **the quoted benefit information of coverage is not a guarantee of payment by an insurance carrier.** Insurance carriers routinely review claims and change payment and medical necessity determination. In addition, I am aware that coverage may be reduced by services received at another provider. I am ultimately responsible for my benefit information as it relates to my condition.

b. SELF- PAY: I have agreed to self pay for the treatment program(s) listed below for the reason indicated below. I am aware that Rehabilitation Associates, Inc. will not bill these services to insurance carrier(s).
Treatment Program(s): _____
Reason for Self-Pay: ( ) no insurance ( ) no benefit coverage ( ) benefits exhausted ( ) out-of-network benefits

2. PAYMENT RESPONSIBILITY: I understand that I am responsible to pay co-payments required by my insurance at the time of each visit as well as any accrued deductible, coinsurance, and/or non-covered service(s) balances that have been processed by insurance to date. I *am aware that a billing fee may be incurred if such payment is not made upon first request. A charge may also be assessed for any broken appointments unless 24 hours notice is given.* For your convenience, Rehabilitation Associates, Inc. will accept cash, check or credit card as payment. The parent and /or guardian of a minor are responsible for payment in full for services rendered and should be the signed guarantor. **I understand that I am responsible to immediately inform your office of any changes to my insurance coverage and/or demographic information in order to comply with authorization requirements and filing limitation guidelines of my plan. Therefore, I understand that if I fail to notify your office of any changes prior to services rendered, I will be required to make payment in full for any non-covered services.**

3. EVALUATION AND TREATMENT AUTHORIZATION: I hereby authorize Rehabilitation Associates, Inc., upon the written order of my physician, to evaluate and treat the condition(s) for which I am being referred.

4. AUTHORIZATION FOR TREATMENT OF A MINOR: I, _____ (parent/guardian), authorize Rehabilitation Associates, Inc., to evaluate and treat my son/daughter/charge (circle one) _____(name of client). This does/does not (circle one) include my permission to evaluate and treat the above named minor in my absence.

5. BILL OF RIGHTS: I have received, read, and understand the *Orientation and Welcome Packet & Client's Bill of Rights*.

☐ **MEDICARE PATIENTS:** Rehabilitation Associates, Inc. provided me information explaining the Outpatient Therapy Caps.
☐ ***I am not currently receiving any homecare services and will inform Rehabilitation Associates, Inc. prior to any homecare services being instituted.***
☐ ***I am currently receiving homecare services and have provided Rehabilitation Associates, Inc. with the appropriate information.***

Thank you for reading our Financial Policy. Please let us know if you have any questions or concerns. **I HAVE READ THIS FINANCIAL POLICY FOR REHABILITATION ASSOCIATES, INC. AND I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.**

Client Signature: _____ _____ **Print Name:** _____
Date

If Client is not financially responsible, please have the financially responsible party sign and date below:

_____ _____ **Print Name:** _____
(Responsible Party) Date
Relationship to Client: _____ ☐ **Provided Responsible Party SSN# to Office**
Explanation of why client did not sign: _____

Witness' Signature: _____ _____
(Rehabilitation Associates, Inc. employee will witness) Date
**If the client has not signed this Financial Policy Authorization and Agreement, please print the Responsible Party's name, relationship to the client and explain why the client did not sign. The responsible party assumes full financial responsibility for the account balance. The statement should demonstrate that the above signer is authorized to consent to release client information on behalf of the client.*

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PATIENT INFORMATION

CLIENT NAME: _____ DATE OF BIRTH: _____

ACCIDENT RELATED? (Please circle one) YES NO; IF YES, PLEASE ANSWER THE FOLLOWING QUESTIONS:

DATE OF ACCIDENT: _____

TYPE OF ACCIDENT: (Please circle) MOTOR VEHICLE WORK OTHER LIABILITY SLIP / FALL ACCIDENT

HOW ACCIDENT OCCURRED: _____

WHERE ACCIDENT OCCURRED (INCLUDE STATE): _____

INSURANCE COMPANY: _____ CLAIM NUMBER: _____

HAVE YOU RETAINED AN ATTORNEY FOR THIS ACCIDENT? YES NO; IF YES, PLEASE COMPLETE THE FOLLOWING:

NAME OF ATTORNEY/LAW OFFICE: _____

ADDRESS OF LAW OFFICE: _____

_____

_____

_____

ATTORNEY'S PHONE NUMBER: _____

WRITTEN ACKNOWLEDGEMENT – NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a Notice of Privacy Practices for Rehabilitation Associates, Inc. I understand that if I have further questions or complaints about the Privacy Notice I may contact: Kelly Dellapiano, Privacy Officer at (203) 384-8681

I also understand that I am entitled to receive updates upon request if this Notice of Privacy Practices of Rehabilitation Associates, Inc. is amended or changed in a material way.

_____ or _____
Patient's Signature Patient's Personal Representative

_____
Date

TO BE COMPLETED BY REHABILITATION ASSOCIATES, INC.
IF UNABLE TO OBTAIN THE ABOVE ACKNOWLEDGEMENT

On _____ I attempted to obtain the above written acknowledgement, however the patient declined to sign.
(Date)

_____ _____
Signature of Employee Title of Employee

Appointment Reminders: Offered either by email or text, please choose one option below:

__ Email: _____
__ Text: phone number: _____ Carrier: _____
__ No appointment reminders