

## 498 Inman Ave. Suite 200, Colonia, NJ 07067

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Date:



### CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorizeFYZICAL THERAPY & BALANCE CENTER of Colonia through its appropriate personnel, to furnish medical care and treatment to me, or the above named patient, considered necessary and proper in diagnosing or treating my/his/her physical condition.

I further authorize FYZICAL THERAPY & BALANCE CENTER of Colonia to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

I understand that the objectives of Physical Therapy treatment are to relieve my pain and increase my functional ability. While it is expected that we will meet our objectives, I also understand that with a condition like mine there is no guarantee. I am entering into this program hopeful yet with the full understanding that my expectations may not be met.

I agree that any dispute shall be resolved by binding arbitration under the rules of the American Arbitration Association. The word of the arbitrator(s) shall be final and binding upon both parties. A demand for arbitration must be in writing and must be made by the aggrieved party. Signature: Relationship to patient: Self Guardian Other: CONSENT TO REPRESENTATION IN APPEALS AND ARBITRATION OF CLAIMS I agree to representation by FYZICAL THERAPY & BALANCE CENTER of Colonia in an appeal of an adverse utilization management determination as allowed by NISA 26:2S-11, and release of personal health information to the NJ Dept. of Banking and Insurance (DOBI), its contractors for the Independent Health Care Appeals Program, and independent contractors reviewing the appeal. My consent to representation and authorization of release of information expires in 24 months, but I may revoke both sooner. I also agree to the release of personal health information to DOBI, its contractor for the Independent Claims Arbitration Program, and any independent contractors that may be required to perform the arbitration process. My authorization of release of information for purposes of claims arbitration will expire in 24 months. Signature:\_\_\_\_ Relationship to patient: Self Guardian Other: PHOTO/VIDEO RELEASE I hereby DO / DO NOT grant and authorize FYZICAL THERAPY AND BALANCE CENTER of Colonia the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any or all pictures of videos taken of me to be used in and/or for legally

I hereby DO / DO NOT grant and authorize FYZICAL THERAPY AND BALANCE CENTER of Colonia the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any or all pictures of videos taken of me to be used in and/or for legally promotional materials including but not limited to, websites, and social media networks such as Instagram, Facebook, and Tiktok without payment or any other consideration. This authorization extends to all languages, media, formats, and markets now known or hereafter devised. This authorization shall continue indefinitely unless I revoke said authorization in writing.

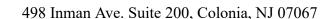
Name:

Signature:



# **Statement of Financial Responsibility**

Patient Name:	Date:
FYZICAL THERAPY & BALANCE CENTER of Colonia appreciates the confidence y for your rehabilitative needs. The service you have elected to participate in impart. This responsibility obligates you to ensure payment in full of your fees. And bill your insurance carrier on your behalf. However, we are not responsible for the payment of your bill.	nplies a financial responsibility on your As a courtesy, we will verify your coverage
You are responsible for payment of any co-payment at the time of service and deductible/coinsurance as determined by your contract with your insurance can additional stipulations that may affect your coverage. You are responsible for your insurance carrier denies any part of your claim, or if you and your physici approved periods, you will be responsible for your account balance in full. You collection fee that occurs as a result of your account being forwarded to a collection fee that occurs as a result of your account being forwarded to a collection fee that occurs as a most major credit cards. Payment is accepted by pays statement. Payments can be made in the office or mailed to the address on your account the sum of the sum	arrier. Many insurance companies have any amount not covered by your insurer. If an elect to continue therapy past your u are responsible for paying any type of ection agency. For your convenience, we ment due date on your monthly patient
For Medicare Patients Only: If Medicare denies a claim due to overlapping concording services, we will make every effort to verify Medicare coverage and limitations or out-of-pocket responsibilities. By receiving therapy services at or agrees to the following:  - Medicare may deny claims for services if the patient is currently under an HH-The patient will be financially responsible for any denied claims unless others. The patient has the right to appeal any denied claim and will receive assistance.	the cost of services rendered. Prior to inform patients of any potential coverage ur clinic, the patient acknowledges and IC episode or receiving therapy elsewhere. wise prohibited by Medicare regulations.
I have read the above policy regarding my financial responsibility to FYZICAL TI providing rehabilitative services to the above named patient or me. I certify the of my knowledge, true and accurate. I authorize my insurer to pay any benefit CENTER of Colonia. I agree to pay FYZICAL THERAPY & BALANCE CENTER of Colonical incurred by me or the above named patient, if applicable, any amount due after insurance carrier, as well as any type of collection fee that occurs as a result of collection agency. I understand I am financially responsible to FYZICAL THERAL charges not covered by the authorization.	hat the information provided is, to the best ts directly to FYZICAL THERAPY & BALANCE blonia the full and entire amount of all bills er payment has been made by my f your account being forwarded to a
Signature:	Date:





#### BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this section. I authorize FYZICAL THERAPY & BALANCE CENTER of Colonia to disclose my health information that is directly related to my current treatment at FYZICAL THERAPY & BALANCE CENTER of Colonia to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

NAME:	RELATIONSHIP:		
Signature:	Date:		
(Relationship to patient self—guardian—other:	)		
HEALTH INSURANCE PORTABILIT	TY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)		
FYZICAL THERAF	PY & BALANCE CENTER of Colonia		
<ul> <li>detailing FYZICAL THERAPY &amp; BALANCE CENTER of Colonia</li> <li>b) May be required by State law to maintain greater restrictederal law. FYZICAL THERAPY &amp; BALANCE CENTER of Colocolistic required to abide by the terms of this Privacy Notice</li> <li>d) Reserves the right to change the terms of this Privacy Notice that it maintains.</li> <li>e) Will comply with our complaint policy and will not retain by signing my name below, I acknowledge that I have read BALANCE CENTER of Coloniathe expressed written consent to the privacy of the colonial of the privacy of the colonial of the</li></ul>	ictions on the use or release of your PHI than that which is provided under onia is required to and will comply with all required State statutes. and will distribute any revised Privacy Notice to you prior to implementation. Notice to make the new Privacy Notice provisions effective for your entire PHI liate against you for filing a complaint. d and understood the Privacy Notice. Furthermore, I give FYZICAL THERAPY & to display my name in any "In-Office" usages, including but not limited to sing-ind that if my name is requested to be used for promotional purposes outside of		
Signature:	Date:		
Relationship to patient: Self Guardian Other:			
FYZICAL THERAPY & BALANCE of Colonia request	ATION POLICY  ats 24 hours notice upon canceling an appointment. If prior notice is not		

committed to you 100% and expect your commitment in return. Signing this agreement confirms your consent to these terms.

Name:	
Signature:	Date:



## **MEDICATION LIST**

Patient Name:	ıt Name:			
MEDICATION	DOSAGE	FORM	ADMINISTRATION	FREQUENCY
				,

Medication list reviewed by Dr. Thomas DiPaolo, PT, DPT.