ADVANCE
— for kids —
PEDIATRIC
Physical, Occupational,
and Speech-Language Therapy

Conditions of Admission

Authorization for Treatment

I, the undersigned, hereby authorize and consent to rehabilitation services provided by Advance Rehabilitation for Kids, Inc. including any procedures which may be performed during this visit for:_____
Patient Name

Assignment of Insurance Benefits and Release of Information

I hereby assign and authorize direct payment to Advance Rehabilitation for Kids, Inc. of all insurance benefits payable to me under the terms of any insurance policy for the services rendered, but not to exceed the regular charge for services received. I authorize any holder of medical information about me or any information needed to determine benefits payable for related services to be released to my insurance carrier, third party payor, and managed care organization or to any other insurance carrier, including worker's compensation claims. I authorize a copy of the authorization to be used in place of the original.

Medicaid Authorization and Assignment

I request that payment of authorized Medicaid, Medigap or other Medical Assistance programs be made on my behalf to the above provider for services furnished to me by the provider/supplier. I authorize any holder of medical information about me or any information needed to determine benefits payable to be released to my insurance carrier. My signature certifies that I have received a service beginning with the date below. I understand that payment for this service will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State Law.

Personal Valuables

It is understood and agreed that Advance Rehabilitation for Kids, Inc. is not responsible for loss or damage to any personal valuables or properties.

Financial Agreement, Guarantee of Account

I, the undersigned agree whether I sign as parent, guardian, spouse, agent, guarantor or as patient, that in consideration of the services to be rendered to the patient , I hereby individually obligate myself to pay the account of Advance Rehabilitation for Kids, Inc. in accordance with the regular rates and terms of the Facility.
I understand that therapy services are rendered and charged to the patient and not to the insurance company, and the facility cannot accept total responsibility for collection of claims nor for negotiating a disputed settlement.
I agree to be responsible for all deductibles, coinsurance and non-covered portions of services performed.
I understand that Advance Rehabilitation for Kids, Inc. is not a party to any lawsuit I may have due to litigation. I further understand that although information will be provided to my attorney, I am fully responsible to the provider for payment in full under the regular terms of the practice.

Should the account be referred to a collection agency or attorney for collection, I shall pay actual attorney's fees and collection expense.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS AND ACCEPT ITS TERMS

_____ _____ _____
Signature of Patient or Responsible Party **Relationship to Patient** **Date**

_____ _____
Witness **Date**