PATIENT RESPONSIBILITY FORM

1. INDIVIDUALS FINANCIAL RESPONSIBILITY

   I understand that I am financially responsible for my health insurance deductible, co-insurance or non-covered service.

   Co-Payments are due at the time of service.

   If my health insurance plan requires a referral, I must obtain it prior to my visit.
   In the event that my health insurance plan determines a service to be Anot payable,@ I will be responsible for the complete charge and agree to pay the costs of all services provided.

   If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
   I hereby authorize and direct payment of my medical benefits to Arnold Physical Therapy, P.C., on my behalf for any services furnished to me by the provider.

3. AUTHORIZATION TO RELEASE RECORDS
   I hereby authorize Arnold Physical Therapy, P.C., to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.
   I hereby authorize Arnold Physical Therapy, P.C., to release to my referring physician, and to the person listed below (spouse, family member, friend B in case of emergency) all information regarding treatment I receive from Arnold Physical Therapy, P.C.:

   Referring Physician: _____

   Other: _____ Phone No.: _____

SIGNATURE: _____ DATE: _____

WITNESSED BY: _____ DATE: _____