

**BLUE BELL PHYSICAL THERAPY  
PATIENT FINANCIAL RESPONSIBILITY**

Patient name \_\_\_\_\_

Thank you for choosing Blue Bell Physical Therapy for your rehabilitation needs. You can expect quality, hands on, personalized care that will generate results. In exchange, we expect that, after undergoing a full explanation, you understand your financial responsibility. This responsibility obligates you to ensure payment in full of our fees. We will verify your insurance coverage and bill your insurance carrier on your behalf. By doing so, we will meet our obligation to ensure that your insurance carrier has all the necessary information to make payments on your behalf, however, you are ultimately responsible for payment of your bill.

**You are responsible for payment of any deductible and co-payment/co-insurance as stated by your contract with your insurance carrier.** We expect these payments when services are rendered. Please be aware that some insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your carrier. If your insurance carrier denies any part of your claim, or, if after consulting with your physician, the need exists to continue therapy beyond the approved coverage by your insurance carrier, you will be responsible for your account balance in full.

Medicare covers Outpatient Physical Therapy, Occupational Therapy and Speech-Language Pathology services at 80% of the Medicare Fee Schedule rate after a \$100 annual deductible. Your secondary insurance may cover all or part of these required fees. Medicare does not disclose information regarding coverage eligibility for these fees to providers.

I have read the above policy regarding my financial responsibility to Blue Bell Physical Therapy for providing rehabilitative services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits to Blue Bell Physical Therapy. I also agree to pay Blue Bell Physical Therapy the full and entire amount of all bills incurred by me or the above named patient; or, if applicable, any amount due after payment has been made by my insurance carrier.

PATIENT

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

GUARANTOR

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(if guarantor is not the patient)

**BLUE BELL PHYSICAL THERAPY**

1524 DEKALB PIKE  
BLUE BELL, PA 19422  
(610) 275-0330

**Patient Medical Information Release**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize disclosure of my protected health information regarding my present medical problem to the following healthcare individuals: Please check all that apply.

- General Practitioner
- Orthopedic Doctor/ Surgeon
- Neurologist
- Rheumatologist
- OBGYN
- Chiropractor
- Insurance
- Work (Workers Comp.)
- Other: Please list

\_\_\_\_\_  
\_\_\_\_\_

This authorization will expire at the termination of your treatment.

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to subsequent disclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed and signed authorization form.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient (if signed by a personal representative of patient): \_\_\_\_\_

**Consent for Treatment**

I hereby authorize Blue Bell Physical Therapy through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures relating to my diagnosis.

I further authorize Blue Bell Physical Therapy to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
(or parent if patient is a minor)