STATEMENT OF FINANCIAL RESPONSIBILITY

To help you better understand your obligations, please read the following. If you have any questions or are unsure about your responsibilities for services being rendered at Excel Therapy, please speak to the receptionist. You can also request to speak to one of our billing specialists. Please make sure you understand your financial arrangement and Excel Therapy's policies before signing this agreement.

1. MEDICARE PATIENTS:
   After you met your annual deductible, Medicare typically covers 80% of our charges. You are responsible for the deductible, as well as the 20% co-insurance per visit. If you have a secondary insurance that covers the deductible and/or the 20% co-insurance, we will bill your secondary insurance on your behalf. If payment is denied, or we do not participate with your secondary insurance provider, you will be responsible for all services rendered by Excel Therapy.

2. COMMERCIAL INSURANCE:
   Excel Therapy is fee-for-service practice and dose not participate with any commercial insurances. Payments may be made by cash, check or credit card at the time services are rendered. For your convenience an itemized statement will be provided with all the necessary information required to allow you to submit for out of network coverage.

3. MOTOR VEHICLE:
   If you were in a motor vehicle accident and want us to bill your car insurance, please be advised you will be responsible for full payment at the time of service. As a courtesy our office will verify that you have an "open case" and your insurance provider is willing to cover your treatment. Many insurance providers require prior authorization to continue treatment after your initial evaluation. We will submit an authorization request until we receive the authorization, we will not schedule any further appointments.

   Receiving authorization from your insurance provider is not a guarantee of payment. Payment for our services can subsequently be denied. Denials may occur for various reasons (ex: receiving chiropractic services for treatment related to this accident; benefits have been exhausted; result of Independent Medical Exam (IME) deems treatment not medically necessary, etc.). It is your responsibility to understand your insurance benefits. If you receive notification that your benefits have been exhausted please let us know, as ultimately you will be responsible for all services rendered by Excel Therapy.

PRIVACY RELEASE OF INFORMATION

I, ______________________ hereby give Excel Therapy permission to contact me and leave a message, at the phone numbers and/or email address listed below regarding my care.

- Home: _________________________
- Cell: _________________________
- Email: _________________________

The following individuals can receive information regarding my care from Excel Therapy:

Name	Relationship
___________________________	___________________________________
___________________________	___________________________________
___________________________	___________________________________

PATIENT ACKNOWLEDGEMENT OF PRIVACY PRACTICES (HIPAA) AND STATEMENT OF FINANCIAL RESPONSIBILTY

By signing below, you have read the billing guidelines regarding financial responsibilities for service rendered, and authorize Excel Therapy to bill your insurance and for your insurer to pay any benefits directly to Excel Therapy of NJ corp.

I authorize Excel Therapy to release my information. Excel Therapy is committed to ensuring the privacy and confidentiality of our patient's Protected Health Information (PHI) which includes all billing information. Excel Therapy uses and discloses such information only according to our strict confidentiality policies and Federal and State laws. This information is used to treat you, receive payment, and for other health care operations. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies. You have the right to review this notice prior to signing this consent. You may ask us to restrict the use and disclosure of your PHI. However, we are not required to agree to a request; but if we do agree, we are bound by law to the agreed upon restrictions.

Patient/Guardian Signature: ________________________________ **Date:** __________________

MEDICAL HISTORY

Last Name: ___________________________________First Name: ______________________ DOB________

Address: _____________________________

____

Referring MD: __________________________

Reason for today's visit:

____

____

List of medications:

____

Please note any other pertinent past medical history:

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Cancellation and Late

Policy / Credit Card

Information

- If you need to cancel or reschedule a session, you are more than welcome to do so, as long as you provide more than 24 hours notice before your scheduled appointment.

- If you cancel within 24 hours of your appointment this is considered a Late Cancellation and we reserve the right to charge you a $75 cancellation fee.

- While traffic has become increasingly unpredictable, we cannot guarantee a full appointment if you are running late as we have reserved that time following yours for someone else.

- Please provide your credit card information which will only be used with your permission for payments of service or cancellation fees.

- Credit card number______________________________

Expiration date_________ Zip Code ___________ CVV__________

Patient/Guardian Signature: _________________________________ Date: _________