



In-Home
Therapy Services

Revive Rehab Services, LLC

Office Phone: (484)891-0608

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NOTICE OF PATIENT PRIVACY AND FINANCIAL AGREEMENT

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

How Medical Information About You May Be Used And Disclosed And How You Can Access This Information

We may require your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment. We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask us and we will provide you with a copy. If you have any questions, concerns, or complaints about the Notice or your medical information, please contact Revive Rehab Services, LLC at [\(484\)891-0608](tel:4848910608)

Release Of Medical Information Necessary to Process Claims

I authorize the release of all medical or other information needed to process this medical claim. I also request payment of government benefits to the party who accepts assignment below.

CANCELLATION POLICY

We require 24 hours notice in the event of a cancellation. There is a **\$100.00** charge for a cancellation without proper notice. Your insurance will not cover the penalty amount and you will be responsible for this charge. Missed/late canceled appointments prevent other patients the opportunity for an appointment and affect the consistency of your own rehabilitation program. The therapist will not be able to reschedule on short notices and must accommodate for lost work time/travel.

Assignment of Benefits / Consent for Physical / Occupational / Speech Therapy

I, the undersigned do hereby agree and give my consent for Revive Rehab Services, LLC to furnish physical, speech and or occupational therapy to myself or dependent, which is considered necessary and proper in evaluating and treating myself or dependent for my/their physical condition. I assign them all payments for medical services rendered. I acknowledge that they will bill my insurance company on my behalf. In the event medical payments are received directly by me for services rendered that have not been paid for, I promise to immediately sign over and forward those payments along with the Explanation of Benefits to In Home Therapy Services of San Diego. I accept financial responsibility for all charges incurred. I understand that I am to pay any deductibles, co-payments, or other charges not covered by my insurance company. If my account has to be referred for outside collections, I will be charged a \$30 service charge. For all returned checks, there is a \$20 penalty in addition to the immediate cash payment for services rendered. I also authorize Revive Rehab Services, LLC to furnish any necessary information concerning injury /illness to the insurance carrier involved.

I have read and fully understand the above information.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____

Date: _____