Notice of Privacy Practices
and
Financial Policy

HULST JEPSEN
PHYSICAL THERAPY

I acknowledge receipt of this notice of privacy practices. I understand that I may request additional restrictions on the use and disclosure of my protected health information or for additional confidential treatment of communications.

X ____
Signature of patient or personal representative Date

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Printed Name of Patient Relationship to Patient

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(FOR OFFICE USE ONLY)

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Reason Initials Date

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We are committed to providing you with the best possible care. If you have insurance coverage, we are anxious to help you receive your maximum allowable benefits. To achieve this goal, it is very important that you supply us with complete and accurate insurance information, including secondary coverage if any.

As a service to you, **Hulst Jepsen Physical Therapy Inc**. will bill your insurance carrier directly. However, you must understand that your insurance coverage is a contract between you and your insurance company and that, ***ultimately, you are responsible for your account***. If full contracted payment is not received from your insurance company; you will be billed for the unpaid balance. Payment is then required within 30 days of notification, unless other arrangements have been made with our business office.

NOTE: If your injury is covered by worker's compensation, your personal responsibility may be waived. Please ask for a Work Comp disclosure form.

Assignment and Release

I agree to the terms and policies presented above and hereby request and authorize **Hulst Jepsen Physical Therapy Inc** to treat me and/or my dependent child.

I certify that I and/or my dependents have insurance coverage and assign payment of benefits directly to **Hulst Jepsen Physical Therapy Inc** for all physical therapy services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Should the insurance company issue payment directly to me for these services, *I will pay the full amount issued*, to Hulst Jepsen Physical Therapy Inc within 15 days from my receiving payment.

I authorize the use of this signature on all insurance submissions. I also authorize the release, for medical and/or billing purposes, all information acquired in the course of my and/or my dependent child's treatment.

X ____
Signature of Patient, Parent or Legal Guardian Date