Divine Spine Physical Therapy and Yoga
7 Centre Dr suite 9, Monroe, NJ 08831
P: 908.444.6055 • F: 732.328.2723

Welcome to Divine Spine Physical Therapy,

It is your responsibility to know the requirements of your insurance company. This includes requirements, second opinion, prior approval, precertification, participation, in network, out of network, referral and outpatient and/or inpatient status. You are responsible for all co-payments, co-insurance and deducible required by your insurance plan, at the time of service, unless otherwise agreed upon by Divine Spine Physical Therapy. You must be aware of any pre-existing conditions, waivers or waiting periods, outlined by your insurance carrier.

Consent to Physical Therapy Evaluation and Treatment: I hereby consent to evaluation and/or treatment of my condition by licensed physical therapist employed by or under contract with Divine Spine Physical Therapy. The physical therapist has fully explained to me the nature and purposes of the procedures, evaluation and course of treatment, and has witness my signature of this consent in his or her presence. The physical therapist has informed me of expected benefits and possible complications or discomfort which may result from skilled physical therapy care. In addition, the physical therapist has explained to me the risks of
receiving no treatment. The physical therapist has explained that there is no guarantee that the proposed course of treatment will improve my condition and that is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition. I have been given on opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form.

Release of Information: I authorize Divine Spine Physical Therapy to make available and disclose any part of my medical record and/or financial ledger, to my insurance carrier(s), or other entity necessary to determine insurance benefits or the benefits payable for related medical services and /or supplies provided to me by Divine Spine Physical Therapy for injuries sustained as a result of an accident or illness. A copy of this authorization will be sent to my insurance carrier(s), other medical entity, attorney, or workers compensation representative if requested. The original authorization will be kept on file by Divine Spine Physical Therapy.

Assignment of Benefits: I authorize direct remittance of payment from all insurance benefits or attorney(s) to Divine Spine Physical Therapy for all covered medical services and supplies provided to me during all courses of therapy and care provided to me by Divine Spine Physical Therapy. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment is considered as effective as the original.

Financial Responsibility: I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible for any charges not covered by health care benefits and regardless of the outcome of my suit or negotiations as presented by Divine Spine Physical Therapy. It is my responsibility to notify the office staff of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the clinic or my health care insurer if the submitted claims or any part of them are denied for payment or are paid directly to me. The intake and verification of benefits form is only an explanation of coverage obtained from my insurance

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company and is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment of services. I understand that my good-faith payment may not be inclusive of all payments for which I am responsible and I may be billed for any remaining balance. If any payment is made directly to me for services billed by us, you recognize an obligation to promptly submit same to Divine Spine Physical Therapy. If I make a payment by check that has insufficient funds, I authorize Divine Spine Physical Therapy to collect the non-payment, plus $25.00 retuned check fee. I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Collection: I understand and agree that if you have to engage the services of an attorney to collect any monies, fees, or charges which I owe you for services rendered that I am responsible for any reasonable attorney's fees that you incur. I further understand that if you must file a legal action against me that I am also responsible for any costs you incur in that regard. Finally, I agree that if you have to file any litigation to collect any sums due by me that I consent to the jurisdiction of the Superior Court of New Jersey, Middlesex County.

Cancel/Missed Appointments: If I miss an appointment or cancel an appointment with less than 24 hours' notice, Divine Spine Physical Therapy will charge $45 for a missed appointment.

Patient Information and Consent Form: I have read and fully understand Divine Spine Physical Therapy's Notice of Privacy Practices. I acknowledge that I have been provided the opportunity to receive the privacy policy statement of Divine Spine Physical Therapy. I understand I can request a paper copy of the notice at any time. I understand that my personal health information may be used or disclosed for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed if I notify the practice. I also understand that Divine Spine Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. I authorize Divine Spine Physical Therapy to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment. I acknowledge that the information I provided on the intake form/patient data sheet is correct.

I have carefully read and understand the above statements and confirm this with my signature.

Patient/Guardian (Printed Name) Date

Patient/Guardian (Signature) Date

Witness (Signature) Date