

Notice and Acknowledgement

Acknowledgement:

I acknowledge that I have received the attached Notice of Privacy Practices.

Printed Patient Name: _____

Patient or Personal Representative

Signature: _____ Date: _____

If Personal Representative's signature appears above, please describe Personal

Representative's relationship to the patient: _____.

Arlington Rehabilitation for Sports & Orthopedic Injuries

A Division of APT



I hereby give permission for my child, _____, to be treated by Arlington Rehabilitation for Sports and Orthopedic Injuries for therapy services. Therapy services have been explained to me, and I understand this treatment and explanation and approve of said treatment.

The policy of this clinic is that payment is due at the time of service. Insured patients are expected to take care of their fees as services are rendered. Your clear understanding of our financial policy is important to our relationship. Your assistance in complying with our payment policies will help control our overhead expenses, thereby keeping fees reasonable.

Patients who carry health care insurance should remember that professional services are rendered to and charged to the patient and not to the insurance company. When we file a claim for you, you will receive a statement each month if your account has a balance due. Please understand that the insurance carrier may pay less than the actual bill for services. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed benefit/claim. You are responsible for payment of your account within the limits of our office credit policy.

If, for any reason, your account is referred to our collection agency, you will be responsible for all collection costs, court costs and reasonable attorney's fees.

If a carrier should deny coverage for physical, occupational and/or speech therapy, you will be responsible for the account. Failure to keep your account current may result in Arlington Rehabilitation for Sports and Orthopedic Injuries being unable to provide additional services. Credit may be extended upon request in cases of sizable balances. We accept cash, checks, Visa and MasterCard.

A \$25.00 charge will be added to the account for each returned check.

If your insurance card has not been issued to you by the time of your visit, you will be treated as a self-paying patient; payment will thus be expected at the time of the visit and the claim will be submitted for you when we receive a card. Please be sure to notify our office immediately should you change medical insurance carrier, home address or telephone number.

As a client of Arlington Rehabilitations for Sports and Orthopedic Injuries, your signature is required below as acceptance of our office policies and as acknowledgment that you have been advised of these policies. In addition, your signature will service as authorization to release medical account information to your insurance carrier(s) to process your medical claims, as needed.

Your signature also denotes that you recognize and accept full responsibility for all physical, occupational and speech therapy rendered and further authorizes the insurance carrier(s) to pay benefits directly to this clinic if a balance is due.

It is our policy that the parent or guardian accompanying the child to the clinic will be responsible for full payment of the bill. Thank you for your understanding. Please let us know if you have any questions or concerns.

Signature of Patient

Date

Witness

Date

3105 N. Wilke Rd., Arlington Heights, IL 60004
847-255-8690 Fax 847-255-2260
www.arlingtonpediatrictherapy.com

Consent for Release and Use of Confidential Information

I, _____, hereby give my consent to
(Name of Patient)

Arlington Rehabilitation for Sports and Orthopedic Injuries to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all information contained in the patient record of _____.
(Patient's Name)

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Arlington Rehabilitation for Sports and Orthopedic Injuries. I also understand that I will not be able to revoke this consent in cases where Arlington Rehabilitation for Sports and Orthopedic Injuries has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the Arlington Rehabilitation for Sports and Orthopedic Injuries office.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the

patient_____.

EMERGENCY TREATMENT RELEASE

TO WHOM IT MAY CONCERN:

I do herewith authorize the treatment by a qualified and licensed medical doctor of the following minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger my life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach my emergency contact. This release form is completed and signed of my own free will, with the purpose of authorizing medical treatment under emergency circumstances.

Name of Patient: _____ DOB: _____

Home Phone #: _____ Cell Phone #: _____

Home Address: _____

Please specify any medical condition which would be important to inform medical personnel in an emergency (i.e., allergies, blood type, heart condition, diabetes, seizure disorder, medications, etc.)

Please list in order of preference the individuals Arlington Rehabilitation for Sports and Orthopedic Injuries should contact in case of an emergency.

1) _____ Phone: _____

2) _____ Phone: _____

3) _____ Phone: _____

Date or dates when release is intended: _____

Patient Signature: _____ Date: _____

Arlington Rehabilitation for
Sports & Orthopedic Injuries
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Dear Family of _____,

Please complete this form and return to Arlington Pediatric Therapy.

Do you or your child receive SSI (Supplemental Security Income) benefits? ____ Yes ____ No

Are you or your child eligible for Medicare benefits? ____ Yes ____ No

If no, I certify that _____ is not a Medicare beneficiary
(name of client)
and if I /he /she becomes such I will notify you.

Signature

Relationship to APT client

Sincerely,

Christine Weber
Christine Weber

Elaine Sianis
Elaine Sianis