

Insurance Company Information

1. Primary Insurance Company Name		2. Secondary Insurance Company Name	
Policy Holder	Date of Birth	Policy Holder	Date of Birth
Policy Holder Employer	Policy Holder SSN	Policy Holder Employer	Policy Holder SSN
Policy Number	Group Number	Policy Number	Group Number
Address		Address	
City, State & Zip Code		City, State & Zip Code	
Telephone Number		Telephone Number	
Relationship to the Patient (circle one) Self Spouse Child Parent Other		Relationship to the Patient (circle one) Self Spouse Child Parent Other	

Date Reviewed _____ Patient Initials _____ Date Reviewed _____ Patient Initials _____

PATIENT WAIVER

Commonwealth Orthopaedics and Rehabilitation, P.C., appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance company. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payments/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full.

I have read the above policy regarding my financial responsibility to Commonwealth Orthopaedics and Rehabilitation, P.C. for providing rehabilitative services to me or the patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Commonwealth Orthopaedics and Rehabilitation, P.C. I agree to pay Commonwealth Orthopaedics and Rehabilitation, P.C. the full and entire amount of all bills incurred by me or the patient; or, if applicable, any amount due after payment has been made by my insurance carrier.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____
(If guarantor is not the patient)

**CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE
INFORMATION**

I hereby authorize Commonwealth Orthopaedics and Rehabilitation, P.C., through its appropriate personnel, to perform or have performed on me, or the above named patient, appropriate assessment and treatment procedures relating to:

I further authorize Commonwealth Orthopaedics and Rehabilitation, P.C. to release to appropriate agencies, any information acquired in the course of my of the above named patient's treatment.

PATIENT SIGNATURE: _____ **DATE:** _____
(or parent if patient is a minor)

OVER THE COUNTER SALE OF MEDICAL SUPPLIES

There may be occasions when treatment protocols require the purchase of an orthopaedic appliance/soft goods to enhance or progress rehabilitation. In those instances, we do require payment at the time of service.

A claim will be filed with your insurance, and in the event we receive payment from your insurance company, a refund will be issued to you.

SIGNATURE: _____ **DATE:** _____

CANCELLATION POLICY

We understand there are times when you must miss an appointment due to emergencies or obligations to work and family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting a much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a treatment, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance, you personally will be charged a **\$30.00 cancellation fee**, (not your insurance company). If you should fail to show or call, you will be charged a **\$50.00 no-show fee**. Should you cancel less than 24 hours prior to, or fail to show up for your scheduled initial evaluation, you will be held responsible for the evaluation fee.

If time permits, our staff MAY call to remind you of your scheduled appointment. However, should you not receive a reminder telephone call, this will not be accepted as an excuse for a cancelled or no-show appointment.

We appreciate your understanding and cooperation.

PATIENT SIGNATURE: _____ **DATE:** _____

In addition, if you miss two (2) scheduled physical therapy appointments without giving us the appropriate notice as outlined above, you will be discharged from physical therapy at Commonwealth Orthopaedics. Your subsequent scheduled appointments will be canceled. You will be given a list of outside physical therapy offices in the area to set up further treatment.

PATIENT SIGNATURE: _____ **DATE:** _____