Consent for Care and Treatment

I, the undersigned, do hereby give my consent for Arizona Hand Center and Physical Rehab to furnish medical care and treatment as considered necessary and proper in diagnosing or treating his/her physical condition.

X _____ _____

Patient Signature ☐ **OR Guardian Signature** ☐ **OR Responsible Party Signature** ☐ **Date**

Benefit Assignment/Release of Information

I, hereby assign all medical benefits to include major medical benefits to which I am entitled including Medicare, Medicaid, private insurance, and third party payers to Arizona Hand Center and Physical Rehab. A photocopy of the assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information as necessary, including medical records, to secure payment.

X _____ _____

Patient Signature ☐ **OR Guardian Signature** ☐ **OR Responsible Party Signature** ☐ **Date**

Financial Policy Statement

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made at time of service. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your insurance company establishes an internal ***usual and customary fee schedule***, you will be responsible for the difference remaining. If any payments are made directly to you for services billed by us, you recognize an obligation to promptly remit same to Arizona Hand Center and Physical Rehab.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including courts costs, collection agency fees and attorney fees.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

X _____ _____

Patient Signature ☐ **OR Guardian Signature** ☐ **OR Responsible Party Signature** ☐ **Date**

_____ _____

Arizona Hand Center and Physical Rehab **Date**