# ULTIMATE REHAB, LLC

**391 S. Maple Avenue**
**Glen Rock, NJ 07452**
**(201) 857-3860 office (201) 857-3863 fax**


## "NOTICE OF PRIVACY PRACTICES"

**YOUR PRIVACY INFORMATION**

PLEASE LIST THE FAMILY MEMBERS, PHYSICIANS WHO YOU CURRENTLY SEE OR OTHER PERSONS IF ANY, WHOM WE MAY INFORM ABOUT YOUR MEDICAL CONDITION AND YOUR DIAGNOSIS (INCLUDING TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS):
_____

CAN CONFIDENTIAL MESSAGES BE LEFT ON YOUR TELEPHONE ANSWERING MACHINE OR VOICEMAIL?(CIRCLE ONE) YES/NO
H#_____AND CELL#_____

I HAVE RECEIVED A COPY OF THE **NOTICE OF PRIVACY PRACTICES**

**INSURANCE WAIVER**

I UNDERSTAND THAT MY INSURANCE CARRIER MAY REQUIRE AN AUTHORIZATION NUMBER, A PRECERTIFICATION, OR REFERRAL. WITHOUT THIS DOCUMENTATION I UNDERSTAND THAT MAY DENY BENEFITS. IF MY INSURANCE CARRIER DENIES PAYMENT FOR SERVICES RENDERED BY PRECISION CARE PHYSICAL THERAPY, I AGREE TO BE RESPONSIBLE FOR PAYMENT.

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I HEREBY AUTHORIZE ULTIMATE REHAB PHYSICAL THERAPY TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENT AND I HEREBY ASSIGN TO ULTIMATE REHAB PHYSICAL THERAPY ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

**OUR FINANCIAL POLICY**

THE ADULT ACCOMPANYING A MINOR AND HIS/HER PARENT (OR GUARDIAN) ARE RESPONSIBLE FOR THE BILL.

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE WILL NOT BECOME INVOLVED IN DISPUTES BETWEEN YOU AND YOUR INSURANCE COMPANY REGARDING DEDUCTIBLES, CO-PAYMENTS, COVERED CHARGES, SECONDARY INSURANCE , "USUAL &CUSTOMARY" CHARGES, REFERRALS, ETC. OTHER THAN TO SUPPLY FACTUAL INFORMATION AS NECESSARY.

SIGNED:_____ DATED:_____