ASSIGNMENT OF INSURANCE BENEFIT

I hereby agree to be evaluated by Marsh Brook Rehab and agree to such treatment that in the opinion of the physician(s) and therapist(s) is necessary.

I understand that it is my responsibility to obtain any insurance referrals prior to my first Occupational or Physical Therapy appointment. If I schedule and attend my appointments without the proper insurance referrals, I understand that I will be asked to sign a waiver form for all visits, accepting financial responsibility for each visit without a referral.

I understand that it is my responsibility to verify Occupational and Physical Therapy coverage with my insurance carrier(s) and that I am financially responsible for charges not covered by my insurance carrier.

I understand that as a courtesy Marsh Brook Rehab will do their best to obtain accurate therapy benefit information from my insurance company. Insurance companies are not always able to tell the details of a health plan, nor can they guarantee coverage in advance. Insurance payment for treatment is always subject to health plan limitations, restrictions, and coverage criteria often outside of our control or knowledge. For these reasons Marsh Brook Rehab cannot be 100% certain of my therapy coverage either and cannot be held liable for inaccurate or incomplete information given to them by my insurance company.

I understand that it is the policy of Marsh Brook Rehab to ask for back-up health insurance for all Worker's Compensation patients in the event the W/Comp claim is denied. I also understand that it is my responsibility to obtain any health insurance referrals for this back-up insurance prior to my first appointment. If no referral available, and my W/Comp claim is denied, I will be held liable for all charges.

I acknowledge that I have received a copy of the Consumer Bill of Rights and Responsibilities and the Marsh Brook Rehab billing, payment, and cancellation policy.

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Assignment of Insurance Benefit (Medicare Included), Release of Information And Financial Responsibility

- I authorize and request payment of medical benefits directly to Marsh Brook Rehab.
- I authorize the release of any medical information necessary to process my insurance claim(s).
- I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
- I agree that a photocopy of this form may be used in lieu of the original.
- **I accept financial responsibility for any and all charges incurred at Marsh Brook Rehab**, including (but not limited to) any balances which may not be covered by my insurance, such as my deductible, co-insurance, co-payments, and the balance of the usual and customary fee. This balance is payable at the time of service or upon receipt of statement.

Signature: ____ Date: ________________

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