BERGENFIELD PHYSICAL THERAPY & PAIN MANAGEMENT

108 So. Washington Avenue, Ste B - Bergenfield, New Jersey, 07621 Tel (201)384-0200 Fax (201)384-0030

Emergency Contact:

Spouse's Name: _____Work Phone _____ Cell # _____

Nearest Relative not living with you: _____ Phone: _____

Name of Landlord: _____ Phone: _____

Consent for Treatment

I voluntarily consent to the rendering of care, including treatment and performance of the therapeutic procedure. I understand that I am under the care and supervision of the attending Licensed Physical Therapist.

Authorization to Release Form

I hereby authorize the release of any information pertinent to my case to any insurance company, medical providers or lawyer involve in this case.
I authorize Bergenfield Physical Therapy to initiate complaint to the Insurance Commissioner for any reason on my
behalf and/or file an arbitration for continuing treatment and payment of unpaid treatment/s.

Assignment of Benefits

I hereby assign direct payment to Bergenfield Physical Therapy and Pain Management for the services rendered to me.
I understand that I am financially responsible for any unpaid treatment not covered by my insurance, regardless of my
insurance status, whereas claim for payment is as per North Jersey Reasonable & Customary Medical Fee Schedule.
I further acknowledge that should my unpaid financial responsibility go into litigation or collection, I will be ultimately responsible for the court/attorney's fees.
All information on the registration form has been completed. I certify that this information is true and correct to the
best of my knowledge and I will be responsible in notifying your office of any change in my status on the information.
A photocopy of this Assignment shall be considered as effective and valid as the original

Financial Arrangements and Medical Insurance

We are committed to providing you with the best possible care. As a medical provider our relationship is with you
and not with your insurance company. We will process your claim for payment. While the filing of insurance claim
is a courtesy that we extend to our patient, all charges are your responsibility from the date the services are rendered.

1) Applicable payment for services is due at the time services are rendered, unless payment arrangement has been approved in advance by the Billing Dept. We accept cash, checks and credit cards.
2) You are responsible for rejected treatment dates and/or amount reflected in the Explanation of Benefits from
your insurance carrier.

3) A charge of $75.00 may also be made for broken appointments and cancelled appointments without 24 hours
advance notice.
4) Returned checks and balances older than 30 days on the last check received are subject to additional collection
5) Fee and interest charge of 1.5% monthly (18% per annum).

Patient Signature _____ Date Signed _____

Parent/Guardian _____ Date Signed _____

Privacy Practice Acknowledgement

I hereby received the Notice of Privacy Practice and have been provided an opportunity to review it.

_____ _____ _____

Signature over Printed Name **Birth Date** **Date**