Consent for Care and Treatment 護理治療同意書

I, the undersigned, hereby agree and give my consent for City Physical Therapy, P.C. to furnish medical care and treatment to _____ considered necessary and proper in diagnosing and/or treating his/her physical and mental condition.

我，在此簽名，同意 City Physical Therapy, P.C 對_____(姓名)進行護理和治療，採取必要和適當的診斷/治療他/她的身體和精神狀況。

Patient/Guardian Signature 病患/監護人籤名： _____**Date 日期:** _____

Benefit Assignment and Release of Information 福利托付和信息發布

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 City Physical Therapy, P.C. A photocopy of this assignment is to be as valid as the original. I, herby authorize said assignee to release all information necessary including Medical Records, to secure payment.

我特此将我所拥有的医疗福利赋予 City Physical Therapy, P.C，包括医疗福利、医疗保险、私人保险和第三方福利。此证明的复印件与原件同样有效。 我特此授权代理人發布所需要的信息包括医疗记录來確保付款。

Patient/Guardian Signature 病患/监护人签名： _____ **Date 日期:** _____

Privacy Practices 隱私保護

I understand that City Physical Therapy, P.C. will use protected health information (PHI) for the purpose of treatment, payment, and heath care operations. I have been presented with the City Physical Therapy, P.C. Notice of Privacy Practices.

我知曉 City Physical Therapy, P.C.為了治療、付款和健康保健會接触到我的健康信息。The City Physical Therapy, P.C. 已經給我出示了隱私保護通知。

Patient/Guardian Signature 病患/监护人签名： _____ **Date 日期:** _____

Financial Policy Statement 財產政策證明

City Physical Therapy will 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 today. If your insurance company does not remit payment within 60days, 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 company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to City Physical Therapy, P.C. If you pay by check and your check does not clear, you will be charged an additional "Bounced Check Fee" of $50 in addition to any bank charges that we incur.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 colleting monies owed, including court costs, collection agency fees and attorney fees.

City Physical Therapy, P.C. 會給您的保險公司寄送賬單。 在享受相應服務后，您有義務全額支付賬單。 我們要求今天您預付應承擔的部分。 如果您的保險公司在 60 天內沒有支付付款， 您將支付賬單餘額。 如果您的保險公司要求退還付款，退還付款金額將是您的負責。 如果您的公司擁有內部常規收費安排，您將負責差額。

如果您的保險公司將付款直接寄給您， 您應當立即寄回 City Physical Therapy, P.C.

如果您使用支票支付， 支票退票， 您將被罰款 50 美金，以及我們支付給銀行的"退票費"。

我知曉并同意，如果我未能在應允時間內按時支付賬單， 我將負責所有因拖欠產生的額外費用， 包括訴訟費、代理費和律師費。

Estimated Insurance Benefits 預估的保險福利:

_____

_____

Estimated Patient Payment 預估的病患支付:

Deductible 抵扣: _____

Copay/Coinsurance 共同支付: _____

Arrangements made for payment of patient's share 病患支付安排: _____

Patient/Guardian Signature 病患/监护人签名 : _____ **Date 日期**: _____