Patient Name: ____

Statement of Patient Responsibility

1. The **Patient/Responsible Party** is obligated to pay **in full** for services rendered.
2. **Blue Ridge Rehabilitation Associates, Inc.** will verify the patient's insurance benefits. Verification is in no way a guarantee of payment by the insurance company and patient is ultimately responsible for all charges incurred.
3. **Blue Ridge Rehabilitation Associates, Inc.** will file claims with insurance companies and accepts assignment of benefits, when appropriate. After insurance payments are made or if there is no insurance, **Patient/Responsible Party** owes the balance and is expected to pay the balance **in full** upon its presentation unless payment arrangements have been made. Payments may be made by cash, or check.
4. **Patient/Responsible Party** is required to pay any co-payment or co-insurance amount at time service is rendered.
5. Finance charges of 1.5 % per month may be added to accounts with unpaid balances after 30 days. Balances not paid within 90 days after billing date will be turned over to a collection agency. If patient's account is assigned to a collection agency, patient agrees to pay all costs of collection, including 25% agency fees, attorney fees and court costs.
6. **Blue Ridge Rehabilitation Associates, Inc.** is not a Durable Medical Equipment company and can not bill insurance companies for any supplies. We expect payment for all supplies at the time they are given to the patient.

I ACCEPT THE PAYMENT OBLIGATION SPECIFIED ABOVE
I have also received the Health Information Privacy Notice.

____

Patient/Responsible Party   Date

(con'd below)

I hereby authorize release of medical information to my insurance company with regard to medical care and expenses. I authorize payment directly to Blue Ridge Rehabilitation Associates, Inc. by my insurance company. If I receive this care as a resident of a nursing home or adult day care facility, I authorize release of client medical information to the same.

____

Patient/Responsible Party Date

Are you receiving or have you received in the last 30 days ***any*** Home Health Care services?

______ Yes ______ No

If yes, what service was received? ___________________________________

Medicare will not cover outpatient therapy services if the patient has not been discharged by the Home Health Care Agency. All charges for therapy services performed by Blue Ridge Rehabilitation Associates that overlap with Home Health Care services will be the full responsibility of the patient.

I have read and understand the preceding statement.

____

Signature Date