



☐ 133 W. Hunting Park Avenue
Philadelphia PA 19140
Ph: 215.455.5370
Fax: 215.455.5374

☐ 3300 Aramingo Avenue
Philadelphia, PA 19134
Ph: 215.427.2242
Fax: 215.427.2433

www.lafortalezarehab.com

AUTHORIZATION FOR CARE AND TREATMENT

I, the undersigned, do hereby authorized *La Fortaleza Physical Therapy Center* to furnish treatment plan and/ or evaluation findings to _____ considered by them and my doctor at necessary and proper in the treatment of my condition.

Patient/ Guardian: _____ Date: _____

BENEFIT ASSIGNMENT/ RELEASE OF INFORMATION

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: *La Fortaleza Physical Therapy Center*. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/ Guardian: _____ Date: _____

FINANCIAL POLICY STATEMENT

1. It is required that you have complete insurance information at the time of your first visit, if you do not have it with you today, it must be handed in to us on your second visit.
2. *La Fortaleza Physical Therapy Center* will call your insurance company to verify your coverage. This is not to be considered a pre-authorization. If your insurance company requires pre-authorization, you must do that yourself.
3. Your payment responsibilities are for any deductible or co-payment, if any. Until verification of 100% payment, you are responsible for the balance that your health insurance company is not going to pay.
4. If your insurance coverage is through a private health carrier, we will need a signed form. Please keep in mind that if we do not receive a claim form we will bill you directly for services rendered.
5. If your insurance coverage is through Blue Cross Major Medical, we will need at least 2 signed claim forms. Blue Cross Major Medical will reimburse you directly for services billed by us, when you receive payment you should recognize an obligation to promptly remit and send to *La Fortaleza Physical Therapy Center* so that we can credit your account properly.
6. If you are receiving therapy due to an auto accident, the following is needed:
 - Your automobile insurance company name and address.
 - Claim number, Adjuster's name and telephone number.
 - Private health insurance name and claim forms.
 - If you have an attorney, we also need his name, telephone and address.
7. The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges and services rendered to you. If you are considered a Worker's Compensation, we need the following information:
 - W/C insurance company name and address.
 - Claim number, adjuster's name and telephone number.
 - Name, address and telephone number of employer.
 - If you have an attorney we will all so need his/her name, telephone and address.
8. A letter of protections is required for all patients who have an attorney. If the letter of protection is not received, the patient is responsible for the unpaid balance.

The above information has been read and explained to me, I undersigned and agree with my responsibility for the payment of account.

Patient/Guardian/Responsible Party

Date

Center Representative/Witness

Date