Kevin Pallone
Physical Therapy
Bring Mobility to Life
Physical and Occupational Therapy at Home or Clinic
Medicare Provider
Office (561) 859-6711 Fax (888) 737-0680
10151 Enterprise Ctr. Blvd. Suite 107 Boynton Beach, FL 33437
FAU Memory & Wellness Center 777 Glades Rd. Boca Raton, FL 33431

# *Statement of Financial Responsibility*

Patient Name: _____ Date: _____

The service you have elected to participate in implies a financial responsibility on you part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any deductible and co-payment/coinsurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue therapy past your approved period, you will be responsible for your account balance in full.

Your coverage information was verified as the following:

Name of Insurance Company:

Insurance will cover % of charges: _____ % Insurance _____% Patient Responsibility

Deductible per year: $ _____, of which $ _____ has been met

Out of pocket: $ _____, of which $ _____ has been met

Number of Visits Allowed: _____

Co-Pay of $ _____ _____ Each Visit _____Eval Only _____Eval & Re-Eval Only

I have read the above policy regarding my financial responsibility to Kevin Pallone, MPT. PA. for providing rehabilitative services to the above named patient or me. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Kevin Pallone, MPT. PA. I agree to pay Kevin Pallone the full and entire amount of all bills incurred by me or the above named patient, if applicable, and, any amount due after payment has been made by my insurance carrier.

Signature: _____ Date: _____

(relationship to patient: self- guardian - other: _____)

# *Consent of Treatment and Authorization to Release Information*
# *Privacy Practices Acknowledgement*

I hereby authorize Kevin Pallone, MPT. PA. to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures relating to the diagnosis stated by my referring physician. I realize I have the right to refuse any proposed interventions described to me. I have been made aware of the intended interventions, expected benefits, possible risks, and that both benefits and risks are possible with or without the proposed interventions.

I further authorize Kevin Pallone, MPT. PA. to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

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

Signature: _____ Date: _____

(relationship to patient: self- guardian - other: _____)