W.A.B. Physical Medicine and Rehabilitation of PA, PC

Board Certified – Physical Medicine and Rehabilitation

Financial Policy

Your clear understanding of our Financial Policy is important to your care. A health insurance policy is a contract between you and your insurance company. Your insurance company, not this office, determines what amount, if any, you owe. If there is a balance due on your account, you will receive a monthly statement, of which payment is due within 30 days of receipt.

If you cannot meet this requirement, please contact our office for payment arrangements. If your insurance requires a referral, it is your responsibility to make sure we have the referral from your primary care physician.

Your insurance carrier requires that we collect co-payments. Co-payments are due at the time of service. If you are unsure of your co-pay amount, please contact your insurance provider.

If you do not have insurance, we can provide you with a discount for payment on the day of service. If you cannot pay at the time of service, please contact the office to set up a payment arrangement prior to your first appointment.

Consent for Treatment, Records Release, and Assignment of Benefits Form

Before you begin treatment, the law requires that we explain your rights and responsibilities while a patient at our clinic. If you have complaints or concerns about your care, please discuss it first with you the doctor or your primary care provider. If your concern remains unresolved, you may file a complaint with the Privacy Officer/Office Manager. If still not resolved, you may file a report to the Department of Health and Human Services.

Consent for Treatment

By signing this form, I consent to and authorize my health care provider to examine and treat me. I understand that my provider is available to explain the purpose of the procedures and treatment, and that I have the right to refuse the recommended treatment. No guarantee or assurance has been made as to the results that may be obtained.

Release of Medical Records

I understand that it is important that my providers have access to medical records which will help them to safely treat me and manage my care. I also understand that they will release medical information to contracted providers and medical transcribers for purposes of medical care and business operations.

Evaluations and test results generated at this office will be automatically mailed to my referring physician. In many instances a third-party payer or attorney will pay a portion or all of my medical bills. In order for a third-party payer to pay the bills related to my visits at this office, they may require chart notes be forwarded to them. I authorize William Bergin, DO, to release any information to determine the payment related to the medical treatment I receive.

Consent to the Use and Disclosure of Health Information

I acknowledge that I have been made aware of the privacy practices; the notice is posted in the reception area. I understand that I have the right to revoke this consent, in writing, at any time except where this office has already made disclosures in reliance on this consent. This office is not required to agree to all restrictions requested. I understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. William Bergin, DO, reserves the right to change the notice and practices, in accordance with Section 164.520 of the Code of Federal Regulations. I understand that as part of this organization’s treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity or family member, and I consent to such disclosures for these permitted uses, including via fax, phone, or electronic health record.

By signing below, I agree to the above statements.

Signature of Patient/Other: _____ Date: _____

Printed Name: _____ Patient Date of Birth: _____

If Other, Relationship to Patient: _____

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