CORA Rehabilitation Clinics

FINANCIAL RESPONSIBILITY/ ASSIGNMENT OF BENEFITS (Florida)

I understand that I am responsible for paying my co-payments, co-insurance and deductibles at the time of service. I also understand that I am responsible for any balance due after payment by my insurance company.

I, the undersigned, understand that CORA Rehabilitation Clinics will bill my insurance carrier for services rendered upon verification of coverage by my insurance company. I understand that verification of benefits is not a guarantee of payment and my financial responsibility is subject to change. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If my insurance company does not remit payments, I understand that I will be responsible for the balance due in full.

Pursuant to the assignment of benefits herein; I hereby request that my insurance carrier make payment directly to CORA Rehabilitation Clinics for all services rendered by this facility. If my current policy prohibits direct payment to CORA Rehabilitation Clinics, I hereby instruct and direct my insurance carrier to make the check out in my name but send the check to: CORA Rehabilitation Clinics, Inc., 1110 Shawnee Road, Lima, OH 45805. If my insurance carrier makes payments to me I agree to immediately pay over these funds to CORA Rehabilitation Clinics. I also authorize CORA Rehabilitation Clinics to deposit check received on my account when made out to me.
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 of collecting monies owed, including court costs, collection agency fees and attorney fees.
(Name of Patient/Legal Guardian/Parent responsible for payment on account: _____)

Charges related to Workers Compensation injury shall be forwarded to the Workers Compensation Insurance carrier and I will not be held personally responsible for these charges. However, if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

We accept assignment from Medicare, so payment will be made directly to our office. We are required by law to collect the 20% coinsurance either by supplement insurance or it is the patient responsibility. If you do not have any supplemental insurance this will be collected from you at the time of service.

ASSIGNMENT OF BENEFITS

I, the undersigned, hereby assign to CORA Rehabilitation Clinics (hereinafter "Assignee") any and all rights, claims, benefits, and causes of action for personal injury protection benefits and medical payment benefits available to me under the policy affording coverage to me for any and all treatment, services, and medical claims resulting from an automobile accident that occurred on _____. This is to act as an assignment of my rights and benefits to the extent of Assignee's services provided. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered including all costs of collection, including attorney's fees and costs.

Patient statements are sent out about every 35 days. After the third statement without receiving a payment from you nor any response from any of the statements, a collection call will be made but after all of these attempts remain unsuccessful we will be forced to turn the account over to Collections. If this occurs you would not be able to be treated again at any of our facilities until the balance is resolved.

CANCELLATION POLICY

A $20.00 fee will be charged for all cancellations and/or now shows unless 24 hour prior notification is given. Your regular scheduled treatment time will be forfeited following 2 consecutive cancellations or no shows.

ASSIGNMENT OF CAUSE OF ACTION

I hereby assign by this instrument all rights and causes of action in tort, in contract and the laws of Florida against the personal injury protection carrier for its failure to pay for services rendered unto me by Assignee in relation to my accident that occurred on _____.

Please call our Billing Office if you have any questions on your account or if you are unable to pay your balance in full they will be able to discuss payment arrangements with you. The number is 866-493-9410.

_____ _____
Print Name of Patient Date

_____ _____
Patient Signature / Guardian Print and Sign Name Relationship to Patient