# ELDER CARE PHYSICAL THERAPY PATIENT AGREEMENT

## INFORMATION DISCLOSURE

I hereby consent for Elder Care and its staff to use my medical and billing information for treatment, payment, and health care operations. I consent for the release of all or part of my medical and billing information for this period of care to any insurance carrier, workers' compensation carrier or self-insured employer group responsible for paying any part of the Health System charges.

This disclosure for consent may be **revoked in writing** at any time. This revocation cannot apply to information already released based on this consent or to disclosures required by State and Federal laws. The person or organization receiving this information could re-release the information to others and federal law would no longer protect it. I release Elder Care, its staff, employees, officers and directors from any responsibility for such re-release. Contact the speech/physical therapy department at 918-776-0391 for further information or to obtain a copy of our Notice of Privacy Practices.

## ASSIGNMENT OF INSURANCE BENEFITS

I agree that insurance benefits for Elder Care charges payable to the insured are to be made payable to Elder Care. Any payments received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits.

## FINANCIAL RESPONSIBILITY

In consideration for the services provided me, payment is guaranteed for any amount due or such services provided by Elder Care at the Elder Care billed rates. The full amount of such charges, applicable insurance deducible or co-insurance is the responsibility of the Patient or Personal Representative as signed below.

## RELEASE OF RESPONSIBILITY

Elder Care is held harmless from any loss, injuries, damages, claims, or actions that may arise out of my use of personal equipment/items.

☐ I hereby certify that I have read each of the statements and have had each item explained to me. I further certify that I am the patient or I am duly authorized by the patient to accept and be bound by the terms of this Patient Agreement.

______________________________________________________________________

Signature Relationship (if not self) Date

1223 Swan Drive • Bartlesville, OK 74006 • 918-336-8500 • Fax: 918-336-8519
www.abouteldercare.org