Northern Virginia Hand Therapy Center The Upper Extremity Specialists.

Conditions of Registration

THE PRACTICE -Northern Virginia Hand Therapy Center, LLC and/or its therapists, employees, agents or assignees will hereafter be referred to as "The Practice".

CONSENT FOR TREATMENT-The undersigned hereby consents to the administration of such medical treatment, diagnostic and/or therapeutic procedures as required by The Practice rendering care for themselves and/or their child(ren).

AUTHORIZATION & ASSIGNMENT OF INSURANCE BENEFITS -I do hereby authorize The Practice to apply for benefits for services rendered to myself or minor child(ren) under any health insurance policies/programs providing benefits and do hereby also assign and authorize payment of benefits from my (our) insurance company to The Practice. I authorize The Practice to contact the employer or insurance company regarding insurance information, existence of insurance and coverage of my (our) benefits.

RELEASE OF MEDICAL INFORMATION -I authorize The Practice to release any and all of my or my minor child(ren)'s medical records and/or other information and records required by my (our) insurance company or its designated review agents who provide insurance benefits on my (our) behalf, including if applicable, my employer and/or employer's workman's compensation insurance company, the Social Security Administration, or the Centers for Medicare and Medicaid Services, needed to determine benefits and to process insurance claims and secure payment of benefits to either the insured or to The Practice; and authorize any hospital, lab, physician, or other healthcare provider and/or their staffs to release my or my minor child(ren)'s medical records and/or other records and information on myself or my minor child(ren) to The Practice as required for payment of benefits and/or required for medical or any other reasons; and authorize The Practice to release the above mentioned records for any of the above reasons. I agree to pay any applicable charges for having medical records copied.

REFERRALS AND AUTHORIZATIONS -I understand that it is my responsibility, if I (we) have an insurance plan that requires any referrals, pre-certifications or authorization to receive any additional medical services, such as specialty care, to obtain such authorization from The Practice or insurance company prior to such non-emergency services being rendered. Additionally, if any aforementioned procedures are not done, I understand that this may cause reduced or rejected coverage for which I will be held responsible and that any of these aforementioned actions do not guarantee that my insurance company will pay for my (our) child(ren)s claims. Any denial of claims is between the policyholder/subscriber and their insurance. I (we) agree to inform The Practice immediately of any change in insurance coverage and/or benefits and change of personal information.

FINANCIAL AGREEMENT -I agree that payment in full is due at the time of treatment. I, the undersigned (jointly and severally if more than one) further agree that I am legally obligated and responsible and do hereby guarantee payment for all charges incurred by myself, my spouse, my children, step-children or any other extended family members, including but not limited to grandchildren, nieces and nephews. The Practice will file for insurance benefits and accept payments per The Practice's contractual agreements with the insurance company. Any questions or disputes concerning insurance coverage or payment of benefits is a matter between the insurance subscriber/policyholder and the insurance company. Any assistance in this matter granted by The Practice is given strictly as a courtesy and implies no responsibility on The Practice's part for filing, follow through or conformation. Should any balances arise due to insurance co-payments, co-insurance, deductibles, non- covered services/procedures, termination of coverage, not adding a dependent to insurance plan, non-payment at time of service and/or any other reason I agree to pay all charges within 30 days of services rendered. I agree that if for any reason a check is returned on my account I will be responsible for a $35.00 returned check fee in addition to the original fees for services. If the balance is not paid within the 30 days or if agreed upon payment arrangements on my (our) account are not made, I authorize the practice to charge any payment method I may have on file in order to satisfy any overdue balances, I am also aware that the practice has the right to retain the services of an attorney and/or collection agency to assist with the collection of any outstanding balance and to notify the credit bureaus of my (our) delinquencies. I understand that this will affect my (our) credit rating. If this account is placed for collection, I agree that any expenses incurred by such collection actions, including maximum allowed service charge, shall become an additional liability for which I (we) assume full responsibility.

COPY OF SIGNATURE -I permit a copy of this authorization and signature to be used in place of this original on all insurance claim submissions and for the release of any medical records and/or other records and information, as stated herein, whether manual, electronic or telephonic.

CERTIFICATION -I certify that the information I have reported with regard to my (our) insurance coverage is correct and that the above be honored by my (our) insurance carriers.I also certify that I have read the foregoing and as the parent/guardian/guarantor understand and fully accept the terms therein.

I certify that as the Patient/Parent/Guardian/Guarantor I have read, understand and fully accept the Conditions of Registration as stated on this document.

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Signature of Patient/Parent/Guardian/Guarantor Print Name Date