VIOLAND AND MC[illegible]RNEY, P.A. PHYS[illegible]AL THERAPISTS
5024 DORSEY HALL DRIVE, SU[illegible] 103 ELLICOTT CITY, MD 21042 PHONE: (410) 740-1047 FAX: (410) 740-2280

ASSIGNMENT OF INSURANCE BENEFITS AND STATEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize and direct any and all insurance carriers providing benefits to me to pay directly to Violand and McNerney, P.A., Physical Therapists, (hereinafter referred to as "the therapists") such sums as may be due and owing them for professional services and for treatment rendered me. I further authorize the therapists to submit a copy of this authorization for payment to any and all insurance carriers which may be responsible for payment of such sums, including but not limited to coverage for Personal Injury Personal (PIP), general medical coverage, Workers' Compensation and Medicare.

I fully understand that I am directly and personally responsible to the therapists for all the medical bills submitted by them with regard to treatment rendered. In the event that I directly receive any proceeds of any insurance policy, including but not limited to proceeds from any claim under any personal injury protection coverage or Blue Cross/Blue Shield or Medicare coverage, I agree to immediately make payment to the therapists upon receipt of such monies. I understand that this authorization and assignment in no way relieves me of my personal primary obligation to pay for the above stated services, and that signing of this form does not prohibit customary billing by the therapists. I further understand that if my insurance coverage produces insufficient funds, I must pay personally for the above stated services, and in the event that there is a deductible or co-pay charge, it shall be my sole responsibility to pay these charges directly to the therapists. I also understand that any delay in making prompt payment to the therapists of monies received for such services may incur a service charge of 1 1/2% per month (18% annual percentage charge) on any unpaid balance more than 90 days delinquent.

Maryland state law requires that insurance companies process any properly submitted claim for payment within 30 days. I understand that if the therapists have not received payment from my insurance company within 60 days on a properly submitted claim, the amount due on the outstanding claim shall immediately be due and payable to the therapists by me personally upon their request.

Further, I agree to make regular co-payments either on the day of treatment or at weekly intervals. Co-payment charges are those that are not covered by insurance policies and may include deductible amounts or payment for supplies. Co-payment is made at the front desk by cash, check or credit card. Billing of secondary insurance carriers must arranged with the office manager and may be assessed a one-time twenty dollar ($20.00) processing fee.

I understand that the statute of limitations in the State of Maryland is three years from the time services were last performed. In view of this, I hereby agree that the statute of limitations with respect to any claim for fees for services mentioned above will not begin to run until there is a denial in writing by me of any balance claimed to be due and owing to the therapists by me.

If it should become necessary to turn this account over to a collection agency or an attorney for non-payment, I will additionally be responsible for all reasonable court costs, collection fees, and attorney's fee. My account will also begin to accrue a service charge of 1 1/2% per month (18% annual percentage rate) until such time as my account is paid in full. A copy or photocopy of this document shall be binding as an original.

I HAVE CAREFULLY REVIEWED ALL OF THE TERMS AND CONDITIONS OF THE ASSIGNMENT OF INSURANCE BENEFITS AND STATEMENT OF FINANCIAL RESPONSIBILITY, AND I FULLY UNDERSTAND AND AGREE TO BE BOUND BY THIS AGREEMENT.

Signature of Patient or Responsible Party: ______________________________

Witness______________________________ Date__________________

Violand and McNerney, P.A. Physical Therapists
5024 Dorsey Hall Drive, suite 103 Ellicott City. MD 21042 Phone: 410-740-1047 Fax: 410-740-2280

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

TO WHOM IT MAY CONCERN:

YOU ARE HEREBY AUTHORIZED TO GIVE VIOLAND AND MCNERNEY, P.A., PHYSICAL THERAPSITS, OR ANY REPRESENTATIVE OF THAT OFFICE, ANY AND ALL INFORMATION WHICH MAY BE REQUESTED REGARDING MY CONDITION INCLUDING THE EVALUATION AND TREATMENT RENDERED BY YOU AND TO ALLOW THEM TO EXAMINE THE FILMS OF ANY IMAGING STUDY PREFORMED BY YOU, AND ANY RECORDS OR REPORTS WHICH YOU MAY HAVE REGARDING MY CONDITION OR TREATMENT.

SPECIFICALLY, I GIVE PERMISSION FOR THE RELEASE OF:

[] OPERATIVE REPORT(S)________________

[] REPORT(S) OF ARTHOSCOPY ________________

[] X-RAY REPORT(S)________________

[] MYELOGRAM REPORT(S)________________

[] CT SCAN REPORT(S)________________

[] MRI REPORT(S)________________

[] BONE SCAN REPORT(S)________________

[] EMG/NCV REPORT(S)________________

[] REPORT(S) OF BLOOD WORK ________________

[]________________

________________ PRINTED NAME OF PATIENT

________________ SIGNATURE OF PATIENT OR PARENT IF PATIENT IS MINOR

________________ DATE

________________ WITNESS

HIPAA

PERSONAL MEDICAL INFORMATION DISCLOSURE

The Health Information Portability & Accountability Act of 2002 directs that health care providers inform you of your rights regarding disclosure of your personal medical information to other parties. Our office has outlined the types of disclosures, that during the course of your care, may be made available to others and your rights regarding these disclosures.

These rights and disclosures are available in a binder for you to review at the front desk and a copy of these rights and disclosures may be taken with you to retain with your personal records if you wish.

__ I understand my rights about disclosure of my personal medical information. I do not wish to receive a personal copy.

__ A copy of these disclosure rights has been made available for me to read. I have received a personal copy.

________________ PRINTED NAME OF PATIENT

________________ SIGNATURE OF PATIENT

________________ DATE

________________ WITTNESS