Statement of Financial Responsibility

Patient Name: _____ **Date:** _____
Acct #: _____

Kessler Institute for Rehabilitation appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill. Kessler Institute for Rehabilitation is hospital based and bills on a UB-04 claim form.

You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible /coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. For your convenience, we accept cash, checks and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement. Payments can be made at the center, mailed to the address on your statement, or you may access our on-line bill payment system @ **https:\\select4.accelpayonline.com** once a statement is received from the billing office, or by calling our customer service department at 1-866-889-9968.

I have read the above policy regarding my financial responsibility to Kessler Institute for Rehabilitation for providing rehabilitative services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Kessler Institute Rehabilitation. I agree to pay Kessler Institute for Rehabilitation the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier. I understand I am financially responsible to Kessler Institute for Rehabilitation for charges not covered by this authorization. **MEDICARE PATIENTS:** I understand that this Kessler facility is a provider-based location of the main hospital located in West Orange, New Jersey and that I may be responsible for a separate and additional coinsurance payment if I am seen by a physician at Kessler's West Orange, Saddle Brook or Chester hospitals, which I would not incur if this outpatient facility was not a provider based location of the hospital. The actual liability will depend on the actual services furnished by the hospital based on the current charge master. The estimated charges for visits to the facility are

_____
(**MEDICARE:** Amount based upon typical or average charges. Please note that your final costs may be higher or lower, as this is only an estimate).

Signature: _____ **Date**: _____ **Time**: _____
(Relationship to patient: self - - guardian - - other: _____) **OA Initials**: _____

BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this section.

I authorize Kessler Institute for Rehabilitation to disclose my health information that is directly related to my current treatment at Kessler Institute for Rehabilitation to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Such persons involved in your care may include: spouse, children, blood relatives, roommates, boyfriends/girlfriends, domestic partners, neighbors and colleagues.

NAME	RELATIONSHIP

I do not wish to have my health information disclosed to individuals involved in my care.

NAME	RELATIONSHIP

Kessler
INSTITUTE FOR REHABILITATION
A Division of Select Medical

Statement of Financial Responsibility

Patient Name: _____ **Date:** _____
Acct #: _____

I acknowledge that the **Notice of Privacy Practices** is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

Signature: _____ **Date**: _____ **Time**: _____
(Relationship to patient: self - - guardian - - other: _____)

CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Kessler Institute for Rehabilitation through its appropriate personnel, to furnish medical care and treatment to me, or the above named patient, considered necessary and proper in diagnosing or treating my/his/her physical condition.

Signature_____ **Date**: _____ **Time**: _____
(Relationship to patient self—guardian—other: _____)

I further authorize Kessler Institute for Rehabilitation to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

Signature: _____ **Date**: _____ **Time**: _____
(Relationship to patient: self - - guardian - - other: _____)

RESEARCH: Research to improve patient care is conducted at this hospital and is approved and monitored by the Institutional Review Board. This review and monitoring assures strict confidentiality with regard to who may view medical records. I consent to the use of information in my record for research purposes. I understand that I might subsequently be asked if I would be willing to participate in research projects if they require activities outside of normal clinical care, and that I have the right to decline participation.

Signature: _____ **Date**: _____ **Time**: _____
(Relationship to patient: self - - guardian - - other: _____)