Hand Health Resources, Inc.
DBA Hand Therapy & Occupational Fitness Center Of Santa Barbara

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits to which I am entitled to Hand Health Resources, Inc., DBA Hand Therapy & Occupational Fitness Center of Santa Barbara in the event that they file an insurance claim on my behalf**.** I hereby authorize Hand Health Resources, Inc., DBA Hand Therapy & Occupational Fitness Center of Santa Barbara to release all information necessary to process claims on my behalf. I agree to be fully responsible for all lawful debts incurred by myself for services received from Hand Health Resources, Inc., DBA the Hand Therapy & Occupational Fitness Center, whether covered by insurance or not. A copy of this agreement shall be considered as effective and valid as the original.

PATIENT RESPONSIBILITY/FINANCIAL POLICY STATEMENT

We will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made at the time of service. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. This also applies if your insurance company requests a refund of payments made to Hand Health Resources, Inc., or the Hand Therapy & Occupational Fitness Center of Santa Barbara.

In the event your Insurance Company establishes an internal **usual and customary fee schedule**, you will be responsible for the difference remaining. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit payment to Hand Health Resources, Inc., DBA the Hand Therapy & Occupational Fitness Center of Santa Barbara.

I understand that I am financially responsible for all charges whether or not paid by said insurance. I also agree to make payments for which I am responsible in a timely manner.

The above may not apply directly to those patients that are filing a Worker's Compensation claim. However, please be advised that if you claim worker's compensation benefits and your benefits are denied, you may be held responsible for the total amount of charges for services rendered to you.

I also understand and agree that if I fail to make 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.

CONSENT TO TREATMENT

I do hereby consent to occupational therapy treatment and services by the authorized personnel of Hand Health Resources, Inc., DBA the Hand Therapy & Occupational Fitness Center of Santa Barbara, including those modalities and procedures as prescribed by my physician dependent upon my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

NOTICE OF NONDISCRIMINATION

Pursuant to TITLE IV of the Civil Right of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, Hand Health Resources, Inc, DBA the Hand Therapy & Occupational Fitness Center of Santa Barbara does not discriminate in the provision of services on the basis of race, color, national origin, disability or age.

I agree to all of the above:

_____	_____	_____
Signature of Patient/Guardian/Responsible Party	**Please Print Name**	**Date**

☐ I have received a copy of the **Notice of Information Practices**. _____ (*please initial*)
☐ I have received a copy of **Patient's Rights and Responsibilities**. _____ (*please initial*)
☐ I have received a copy of the **Cancellation and No Show Policy**. _____ (*please initial*)