Center for Rehabilitative and Sports Therapies
Emerson Hospital

AT LAWRENCE ACADEMY

PATIENT FINANCIAL RESPONSIBILITY FORM

I understand that I am financially responsible for my child's health insurance deductible, coinsurance and co-pays.

In the event that my health plan determines a service to be "not payable" or out of network I will be responsible for the complete charge and agree to pay the costs of all services provided.

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
I hereby authorize and direct payment of my medical benefits to Emerson Practice Associates on my behalf for any services furnished to me by the providers.
By my signature below, I hereby authorize Emerson Practice Associates and the physicians, staff, and hospitals associated with Emerson Practice Associates to release medical and other information acquired in the course of my child's examination and/or treatment to the necessary insurance companies, third party payers, and/or other physicians or healthcare entities required to participate in my care.

____ __________
Signature of Parent or Authorized Representative or Responsible Party Date

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Print Name of Patient, Authorized Representative or Responsible Party and Relationship

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Name of Patient/Child Date of Birth