Exemplary Care at Home
Serving Monmouth and Ocean Counties
P: 732-852-5311
F: 732-852-5965
E: pearlrehabllc@gmail.com

Patient Authorization Record

Please initial the authorizations that apply to you, ignore the ones that do not:

- _____ **Authorization for Treatment: I hearby give authorization for the performance of such rehabilitation procedures as permitted by NJ Statutes under the appropriate scope of practice that are, in the judgement of my Physical Therapist deemed necessary**

- _____ **Authorization for Release of Information: I agree that Pearl Rehabilitation LLC may provide information from my medical record to persons involved in my medical care. I authorize the release of medical information necessary to obtain payment of any benefits available to me to Pearl Rehabilitation LLC for services rendered.**

- _____ **Authorization for Release of Payment: I authorize that direct payment of any benefits available to me be released to Pearl Rehabilitation LLC for services rendered.**

- _____ **Patient Payment Agreement: I agree to take financial responsibility for charges for services rendered to me during my course of treatment, pay any charges not paid by my health insurance, and that EOB from my insurance company is the final word of my financial responsibility. If I fail to pay, I agree to pay any costs related to collection on my account including but not limited to collection costs, attorney fees and court fees. In the event of a returned check, I agree to cover any costs incurred by Pearl Rehabilitation LLC.**

- _____ **Workers Compensation and Motor Vehicle: I agree that the information given to Pearl Rehabilitation in applying for benefits under Workers Compensation or Motor Vehicle is complete and accurate.**

Acknowledgement of receipt of our Notice of Privacy Policy:

I was provided with a copy of the Pearl Rehabilitation LLC Notice of Privacy Practices

Name: _____ Signature: _____

If completed by someone other than the patient, please print and sign your name below

Name: _____ Signature: _____

For Pearl Rehabilitation LLC use only

Complete this section only if this form is not signed and dated by the patient or the patients representative.

I have made good faith effort to obtain a written acknowledgement of receipt of Pearl Rehabilitation Notice of Privacy Practices but was unable to for the following reason:

- **Patient refused to sign**
- **Patient unable to sign**
- **Other:_____**