

Acknowledgment of Patient Policies

The information I submitted in the online registration is true to the best of my knowledge. I authorize and assign my Medicare and/or other insurance benefits to be paid directly to Del Bianco P&O. I authorize Del Bianco P&O and its affiliates to release any part of my medical record and related information required to process claims. In addition, I also authorize Del Bianco P&O to obtain any medical records from my doctor, therapist, or other healthcare/rehab center that may be needed to process/appeal my claim properly. I understand that Del Bianco P&O will file a claim with my insurance(s) on my behalf, but that I am ultimately financially responsible for the entire bill. I understand that without sufficient verification of current medical insurance coverage, payment is due at the time of service/delivery.

By signing below, I also acknowledge acceptance of Del Bianco P&O's HIPAA Notice of Privacy Practices, warranty/refund information, Medicare supplier standards, mission statement, patient rights and responsibilities, and financial policy. These documents are provided for your review on our registration website page by clicking the Patient Policies link. They are also available to you upon request. Please ask if you have any questions about the statements above.

Patient Signature _____ Date _____

Legal Guardian _____ Date _____

Relationship of Guardian to Patient _____