69 Railroad Avenue, Suite A4, Hilo, HI 96720 Ph: (808)339-7861 Fax: (808)339-7989

ASSIGNMENT OF BENEFITS FORM

Name of Insured (print):____

Date of birth:____

□ ________________________________ is my primary insurance

□ ________________________________ is my secondary insurance (leave blank if none)

I request the payment of authorized insurance benefits (including Medicare, if I am a Medicare beneficiary) to be made on my behalf to Core Wellness Hawaii Inc. dba 80/20 Physical Therapy & Wellness (the "Provider") for any services provided to me by the Provider. I authorize the release of any medical or other information necessary to determine the extent of all benefits payable for related equipment or services on my behalf to the (i) the Provider, (ii) the Centers for Medicare and Medicaid Services ("CMS"), (iii) my insurance carrier, (iv) or other medical entity. A copy of this authorization will be sent to CMS, my insurance company, or other entity if requested. The original authorization will be kept on file by the Provider. I understand that this assignment will remain in effect until revoked in writing by me.

I understand that I am financially responsible to the Provider for any charges not covered by health insurance benefits. It is my responsibility to notify the Provider of any changes in my health insurance coverage.

If I am a Medicare beneficiary, I understand that Medicare does not pay for maintenance treatments and that I am responsible for paying for these services out-of-pocket. I also authorize payment of all medical benefits to apply to all occasions for primary and supplemental (Medigap) coverage to be paid to the Provider.

In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the Provider and/or my healthcare insurer if the submitted claims or part of them are denied for payment.

I understand that, by signing this form, I am accepting financial responsibility, as explained above, for all payment and services provided by the Provider. By signing this document, I also acknowledge that I have reviewed the Provider's Notice of Privacy Practices. This acknowledgment is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my rights.

Print name of person signing below:____

Signature of insured or parent/guardian:____

Date:_______________________________________

24 hour Cancellation / No-Show Policy

__24 hour notice__ *is required for all cancellations.*

A ***__$50__*** ***fee*** *will be implemented for all no-shows and late cancellations/reschedules under the required* ***__24 hour notice__****.*

Second occurrence will result in ***__discharge from PT services__*** *and referral back to your physician.*

Arriving for an appointment more than *15 minutes past your scheduled time* will be *__considered a no-show__

For your convenience, additional *__details__* regarding this policy are *__on the back of this page.__*

____________________	____________________	____________
Patient Name	Patient Signature	Date

80/20
PHYSICAL THERAPY + WELLNESS

Comprehensive Late Cancel/Reschedule and No-Show Policy:

At 80/20 Physical Therapy & Wellness, we are committed to providing the highest quality care and service to all our patients. In order to ensure the efficient scheduling and the best possible care for all our patients, we enforce the following Late Cancel/Reschedule and No-Show Policy:

1. **24-Hour Notice**
   Patients are required to provide a minimum of 24-hour notice for any appointment changes or cancellations. This allows us to optimize scheduling and accommodate the needs of all our patients efficiently.
2. **$50 Fee**
   Appointments that are canceled or rescheduled with less than 24-hour notice, or any missed appointments, will be subject to a $50 fee. This fee helps to offset the costs associated with the unused appointment time.
3. **Second Occurrence**
   In the event of a second occurrence of a late cancellation/reschedule or no-show, the patient will be discharged from our services and be subject to our $50 fee. We will then notify your referring physician that services have been terminated and physical therapy services will need to be sought elsewhere.

We understand that emergencies and unforeseen circumstances can arise. We want to assure you that we will evaluate each situation on a case-by-case basis. Decisions regarding late cancels/reschedules and no-shows will be made with careful consideration of the individual circumstances. We will take into account any emergencies or significant mitigating factors that may have contributed to the late cancel, reschedule, or no-show.

This policy is enforced to help ensure fair and efficient scheduling for all our patients, while also maintaining the high standards of care and service that we strive to provide. We appreciate your understanding and cooperation in adhering to this policy and thank you for your continued support of 80/20 Physical Therapy & Wellness.

Thank you for entrusting us with your care and for being a valuable part of our patient community.

Sincerely,
80/20 Physical Therapy