



# Assignment of Benefits (AOB) Form

## Patient Information

Name of Insured (print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Secondary Insurance (if applicable): \_\_\_\_\_

## Authorization & Financial Responsibility

I authorize the payment of insurance benefits (including Medicare, if applicable) directly to **Core Wellness Hawaii Inc. dba 80/20 Physical Therapy & Wellness** (the “Provider”) for services provided. I also authorize the release of necessary medical information to:

- The Provider
- CMS (Centers for Medicare & Medicaid Services)
- My insurance carrier
- Other medical entities as required

A copy of this authorization may be sent to my insurer, CMS, or other entities upon request. This authorization remains valid unless revoked in writing.

## Patient Financial Responsibility

I acknowledge that I am financially responsible for **any charges not covered by my insurance**. This includes but is not limited to **deductibles, co-insurance, denied claims, and non-covered services**. It is my responsibility to verify coverage with my insurance provider.

I understand that **WebPT Billing handles all billing inquiries**. Before submitting a dispute to the clinic, I must first contact **WebPT Billing at (800-478-2778)**. If I do not complete this step, my dispute will not be reviewed, and I remain responsible for all charges.

If I am a Medicare beneficiary, I acknowledge that **Medicare does not cover maintenance treatments** and that I am responsible for payment of these services.

Insurance benefits **cannot always be determined upfront**. If my insurance denies payment, I am responsible for any remaining balance as determined by the Provider and/or my insurer.

## HIPAA Compliance & Privacy Notice

By signing below, I confirm that I have reviewed the **Provider’s Notice of Privacy Practices** as required by HIPAA.

## Acknowledgment & Signature

Print Name of person signing below: \_\_\_\_\_

Signature (Patient/Guardian): \_\_\_\_\_

Date: \_\_\_\_\_



# Zero Tolerance Late Cancellation / No-Show Policy

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- ***24-HOUR NOTICE IS REQUIRED***

Cancellations must be made **at least 24 hours in advance**.

- ***NO FEES***

Although there is no fee for a late cancellation or no-show, **repeat occurrences will impact your access** to services with our facility.

- ***ONE GRACE***

You are allowed **one late cancellation or no-show without penalty**. (*Providing a reason is not necessary*)

- ***SECOND OCCURRENCE = IMMEDIATE DISCHARGE***

A second late cancellation or no-show will result in **immediate discharge** from physical therapy services and a referral back to your physician.

- ***15 MINUTES LATE = NO-SHOW***

Arriving more than **15 minutes past your scheduled time** will be considered a no-show.

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Our commitment to your care is a shared responsibility. Consistent attendance is essential to achieving your goals. By signing below, I acknowledge that I understand this policy and commit to fully participating in my care. I recognize that my attendance impacts not only my progress but also the team's ability to deliver exceptional care to all patients.

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Patient Name

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Patient Signature

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Date

*Updated 01/01/2025*