Physical Therapy Center

25East Willow Street • Millburn NJ 07041
Tel: (973) 564-8878 • Fax: (973) 397-0121

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY AND SIGN WHERE INDICATED

RELEASE AND ASSIGMENT OF BENEFITS

I, the undersigned, hereby authorize the release of all information necessary to any entities to secure the payment of benefits submitted for services rendered by **Physical Therapy Center Management Group LLC**, (known here after as the Provider) on behalf of myself and/or my dependents. I understand information will be provided to a contracted billing service company, to secure payment of benefits. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits for any services rendered without obtaining my signature on each and every claim form, and that will be bound by this signature as thought the undersigned had personally signed the particular claim.

I, the undersigned, have coverage with the insurance companies listed on the Patient Registration Form and assign directly to the Provider all claim benefits, if any, payable to the Provider for all services rendered.

I acknowledge and understand that I am financially and fully responsible for all charges incurred from the services rendered by my provider, whether or not paid by the insurance company notwithstanding any pending legal action resulting from a motor vehicle or other type of accident. I understand any cancellations for appointments require 24-hour prior notification. I understand that I may be billed $50.00 for any missed or canceled appointments without 24-hour notification.

I understand that an authorization number or any pre-coverage information, which may be issued by my insurance carrier, is not a guarantee of payment. I understand that many insurance carriers have separate and distinct guidelines for physical therapy treatment that may differ from standard medical coverage. I understand that I am fully responsible for understanding my plan coverage, terms and conditions for physical therapy treatment. I understand failure to comply with my insurance carrier's terms and conditions may result in non-payment to the Provider and I will be held financially liable for payment.

I authorize the Provider, or its representative to issue a complaint on my behalf to the Department of Insurance and Banking, should the need arise in pursuit of equitable reimbursement for services rendered by the Provider.

If my insurance company for any reason does not reimburse any portion of my account balance, I agree to cooperate and arrange prompt payment to clear my bill. I understand that payment is due upon receipt of my monthly statement. Interest charges will be added to your outstanding balance after 90 days @1 ½ % per month. I understand that I will be legally responsible for all collection costs involved with the collection of my account, including any attorney fees, which are 1/3 of all balances due, any fees incurred for returned checks. In the event that an insurance company reimburses me for services rendered by the Provider, I will supply the Provider with a copy of the Explanation of Benefits. I will also reimburse the Provider all moneys paid to me by my insurance company for services rendered by my Provider.

I have read all the information on this sheet. I certify this information is true and correct to the best of my knowledge. I will also notify Provider of any changes in my health status or information reflected on the Patient Registration Form. If I am hospitalized, involved in an accident or my medical status has changed. I will notify my therapist immediately. I understand I will need a letter of medical clearance from my physician to resume treatment.

_____ _____ _____

Patient Name (Print) **Patient Signature** **Date**