A Note About Your Insurance

With the diverse selection of insurance plans, levels of coverage, and frequent changes, it is not always possible for our office to keep abreast of all plan requirements. While we will do our best to assist and inform you of the requirements, YOU are ultimately responsible for understanding your insurance policy and levels of coverage. If you have any questions or concerns regarding plan coverage and/or administrative requirements, we strongly recommend that you contact your insurance company or your employer to discuss these questions.

Furthermore, some plans require written authorization from your primary care physician (PCP) to see a therapist. Many of these forms cannot be issued retroactively. Therefore, YOU understand that it is YOUR responsibility to obtain a valid authorization from your PCP for each visit, and without this authorization you may NOT be seen. If you insist on being seen without YOUR insurance's proper authorization, YOU agree to waive YOUR health plan benefits. Additionally, YOU agree to be PERSONALLY and FULLY responsible for payment to *Advantage Physical Therapy and Rehabilitation, LLC* for any services rendered.

_____ _____

Signature **Date**

Patient Authorization to File Insurance Claims

I hereby authorize *Advantage Physical Therapy and Rehabilitation, LLC* to apply for benefits for covered services rendered. I request payment from my insurance company and/or Medicare/Medicaid (if applicable) be made directly to *Advantage Physical Therapy and Rehabilitation, LLC*.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information including medical information for this or any related claim to my insurance carrier. I permit a copy of this authorization to be used in place of the original.

Either I or my insurance carrier may revoke this authorization at any time in writing.

_____ _____

Signature **Date**

Financial Policy, Authorization For Treatment & Your Health Information

I authorize treatment and agree to pay all fees and charges for such treatment. I agree to pay all charges promptly upon presentment, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty (30) days of the billing date. In the event legal action should be necessary to collect an unpaid balance due for medical services rendered by the providers of *Advantage Physical Therapy and Rehabilitation, LLC*, I agree to pay reasonable collection and/or attorney's fees.

It is our policy that Payment is Due at the Time Services are Rendered. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pending of claims thereon. All proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for their collection. (A copy of this assignment is as valid as the original).

Our office requires 24 hours advance notice to cancel or reschedule your appointment. Failure to comply with this will result in a failure fee of $50.00.

I acknowledge *Advantage Physical Therapy and Rehabilitation, LLC* will use my information for the purposes of treatment, payment, and health care operations.

I acknowledge that I have been given *Advantage Physical Therapy and Rehabilitation, LLC*'s *NOTICE OF PRIVACY PRACTICES*. I understand that if I have any questions or complaints I may contact the Facility Privacy Official.

_____ _____

Signature **Date**