

ProActive Physical Therapy, LLC

"Be ProActive, Not ReActive"

Payment Authorization

Assignment of Insurance Benefits

Initials

I authorize that the payment of my insurance benefits be made directly to ProActive Physical Therapy, LLC for any services that are reimbursable by Medicare, Medicaid or any third party payors.

Guarantee of Payment

Initials

I understand that all payments designated as "the patients responsibility" are due and payable at the time of service or billing. I guarantee that I will pay:

- My designated portion including co-pays/co-insurance and my deductible.
- All amounts due for services that my insurance company has stated are not covered benefits.
- All amounts due for services billed by ProActive Physical Therapy LLC but paid directly to me.
- All amounts due for services billed by ProActive Physical Therapy, LLC to a Worker's Compensation payor which was subsequently declared by my employer to be a non-eligible claim.
- All amounts due for claims submitted by ProActive Physical Therapy, LLC to my insurance company and not paid by 60 days .

Medicare and Workers Compensation Information

Initials

I certify that the information I have provided to ProActive Physical Therapy, LLC for payment under the Social Security Act (Medicare) or under the Workers Compensation Program is correct, including but not limited to any related accidents/illness or other insurers/payors available.

Cancellation and No Show Policy

Initials

We will make every effort to accommodate your schedule and, with notice, can rearrange appointments as needed. Cancellations required a 24-hour notice so that we may also accommodate others. We reserve the right to charge a \$35.00 rate for habitual no shows or cancellations at our discretion.

I, _____, understand the statements I have authorized above and declare their truthfulness.
Printed Name

Patient or Authorized Representative for Patient's Signature

Date