



AUTHORIZATION AND GUARANTEE

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize the release of any information, including reports of diagnosis, treatment prognosis, treatment recommendation, benefits payable, as well as any other data pertinent to my treatment to the physician referred me for therapy, as well as any organization responsible for payment of my account. I also authorize my referring physician to release to Comprehensive Physical Therapy, Inc. any and all medical or other information pertinent to my treatment.

MEDICARE

I certify that the information given by me in applying for payment under title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and coinsurance.

GUARANTEE OF PAYMENT

In consideration of services rendered to me by Comprehensive Physical Therapy, Inc. I hereby guarantee payment for any and all services rendered to which are not covered or allowable by insurance, together with collection costs, including reasonable attorney's fees. I also understand that all bills are due and payable upon presentation and further agree to pay interest or a monthly service charge on all such amounts not paid when due at the rate of 1.5% per month (18% APR).

RETURNED CHECKS

We are happy to accept your personal check, however, there will be a \$25.00 fee for any check returned for non-payment to Comprehensive Physical Therapy, Inc.

SUPPLIES

All Supplies are not returnable and are non-refundable.

PRIVATE INSURANCE

I understand that as a courtesy, Comprehensive Physical Therapy, Inc. will bill my/insured's private insurance once only for treatment/visits rendered. Should there be any changes in my insurance coverage during the course of physical therapy, I will provide Comprehensive Physical Therapy, Inc. with the new information. Failure of notification can result in possible denial of claim. In the event that payment is not received in 60 days, for any reason, you will be responsible for the full balance and will then need to deal with your carrier directly.

INSURANCE PRE-AUTHORIZATION

As a courtesy we will make every effort to contact your insurance carrier and attempt to make a determination as to your insurance coverage. However, any such determination of coverage is no guarantee of actual coverage or insurance payment for services rendered. We encourage you to contact your insurance company for any benefit information.

APPOINTMENT

I understand that my/patient's appointment will be a time that is exclusively reserved and is not available to anyone else. Should I find it impossible to keep this appointment, I will notify your office within 24 hours prior to my appointment. If I do not show or provide sufficient notification, I agree to pay a \$30.00 fee for each missed appointment.

ASSIGNMENT OF BENEFITS

I authorize that the payment of authorized benefits be made directly to Comprehensive Physical Therapy, Inc. for any services that are reimbursable by Medicare, Medicaid, or any other third party sources.

CONSENT FOR TREATMENT

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or available while a patient at Comprehensive Physical Therapy, Inc.

A COPY OF THIS CAN BE CONSIDERED AS AN ORIGINAL FOR INSURANCE PURPOSES

SIGNATURE OF PATIENT/INSURED

PATIENT'S AGENT OR REPRESENTATIVE

WITNESS BY

DATE