Potential Physical Therapy

WRITTEN ACNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Patient: _____

I, hereby acknowledge that I have received a copy of The Notice of Privacy Practices.

Signature: _____Date_____

Relationship to Patient (if patient is a minor): _____

BILLING POLICY, RELEASE AND AUTHORIZATION

I authorize Potential Physical Therapy, LLC. to bill my insurance company directly for the covered portion of charges, and I authorize payment of benefits directly to Potential Physical Therapy, LLC.

I authorize Potential Physical Therapy, LLC. to release medical or other information necessary to process this claim.

I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier.

I understand that some insurance companies require medical or administrative pre-authorization for treatment or have reimbursement limits on physical therapy treatments. I understand I am responsible for knowing and meeting the requirements of my insurance plan.

Signature: _____ Date: _____