North Naples Physical Therapy

AUTHORIZATION AND ASSIGNMENT

● I request that payment of authorized insurance benefits be made on my behalf to North Naples Physical Therapy, Inc. or if my current policy prohibits direct payment to you, the provider, I will direct payment, endorsing the check that I receive to you an mail as follow: North Naples Physical Therapy, Inc. 9170 Galleria Ct. #200 Naples, Fl 34109. This payment will be for the medical expenses benefits allowable and otherwise payable to you under my current insurance policy as payment towards the total charges for the professional services rendered.

● I authorize physical therapy services under the direction of a licensed Physical Therapist

● This is a direct assignment of my right and benefits under my insurance policy.

● This payment will not exceed my indebtedness to the above mention assignee, and I have agreed to pay in a current manner any balance, of said professional service charges, over and above the insurance payment. I realize that my insurance policy is a contract between my insurance company and I and that the provider is filing claims on my behalf as a service.

● I authorize the release of medical records to my referring physicians, insurance company, adjuster and or attorney involved in this case.

● I authorize the physical therapist to initiate a complaint to the insurance commissioner for any reason on my behalf.

PAYMENT POLICY

● Any outstanding balance after insurance payments will be due within 14 days of notice. If assistance or financial arrangements are needed, you may speak with the financial manager.

● We will bill your primary insurance company. When payment is received, we send it along with a copy of the explanation of benefits to your secondary insurance carrier. We will instruct them to send the payment to us.

● Patients are responsible for all charges not covered by their insurance company, either primary or secondary. This includes your deductible from Medicare and your secondary insurance deductible and any/all co-payments.

● In the event that my insurance company does not cover the physical therapy treatment that is rendered, I will be responsible for payment for medical services.

● I also understand that, should I default on my account, all costs of attorney's fees, interest, and cost of collections would be my responsibility.

PATIENT SIGNATURE_____DATE_____