Assignment of Medical Insurance Benefits

Thank you for choosing Performance Physical Therapy and Rehabilitation, PC. We will work with you to help you with your insurance claims, but would like you to understand our office policy regarding insurance assignment.

Payment is expected at the time of service unless we accept assignment with your insurance company or previous payment arrangements have been made. For our office to accept insurance assignment, we ask that you read and sign the following.

You acknowledge that it is your responsibility to:

1. Provide complete up-to-date information on medical insurance coverage for the patient.
2. Be able to present a valid insurance card when requested.
3. Pay applicable co-payments at the time of service.
4. Present a valid referral or authorization number for all services (if required by your insurance company)
5. Inform us if the patient's need for medical services is due to a motor vehicle, worker's compensation or other accident.
6. Make payment within 30 days any balance on your account for any amount due such as deductibles, coinsurance, co-payments or non-covered services.

You are ultimately responsible to pay the medical bill if your insurance company does not honor the assignment of benefits in whole or in part.

Your signature below indicates:

1. You understand and accept our policy of assignment of insurance benefits.
2. You attest to the accuracy and completeness of the medical insurance coverage information.
3. You authorize this office to release medical information necessary to process your claims and appeals.
4. You authorize payment of medical benefits to Performance Physical Therapy and Rehabilitation, PC
5. I authorize Performance Physical Therapy & Rehabilitation, P.C., to release to MY insurance company or to MY doctor or ANY healthcare professional involved in my care, any information they may request concerning my present condition or treatment.
6. I authorize Performance Physical Therapy & Rehabilitation, P.C. to evaluate and treat my condition with physical therapy procedures under the care of my therapist. (I am aware that I have access to my clinic records upon request.)

Patient or Responsible Party Signature:	Date Signed:
(Responsible Party, Relationship to Patient):	