INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Quality Physical Therapy, LLC (QPT) to release all medical records and information with respect to myself, or my dependents, which may have a bearing on the benefits payable by a payor for services rendered by QPT. I understand that I cannot retract this authorization for the release of medical records until my account balance if fully satisfied.

I understand I am financially responsible to QPT for any co-pays, deductibles or charges not covered by any insurer. I acknowledge that QPT can charge a service fee of $35.00 to my account in the event that I remit payment for services with a check that is returned due to insufficient funds. I understand QPT reserves the right to collect all charges related to patient accounts placed into collections including but not limited to collection agency fees, attorney fees and court costs. I understand and agree to pay interest at the rate of one and one-half percent (1 ½%) per month, eighteen (18%) percent per year, until the entire balance is paid in full.

I assign directly to QPT all medical benefits payable to me for services rendered on my behalf, or my dependents behalf. I authorize the use of this signature for all my insurance submissions, any records I may request for my personal use as well as in my absence permission to leave messages at my home and office.

I understand that my co-pays, deductible and co-insurance are due at the time of service, unless other arrangements are made with QPT.

All patients without insurance coverage are required to make payment at the time of service.

Patient Name (Printed) _____

Patient Signature _____Date_____

Parent/Guardian _____Date_____