PAYMENT AUTHORIZATION

_______ **Assignment of Insurance Benefits**

Initials

I authorize that the payment of my insurance benefits be made directly to WELLNESS WORKS PHYSICAL THERAPY, LLC for any services that are reimbursable by Medicare, Medicaid or any third party payors.

Guarantee of Payment

I understand that all payments designated as "the patient's responsibility" are due and payable at the time of service or billing. I guarantee that I will pay:

_______ My designated portion including co-pays/co-insurance and my deductible.

Initials

_______ All amounts due for services that my insurance company has stated are not covered benefits (**IF** I have been advised by the WELLNESS WORKS PHYSICAL THERAPY, LLC in advance of the service delivery and have authorized it in writing).

Initials

_______ All amounts due for services billed by WELLNESS WORKS PHYSICAL THERAPY, LLC but paid directly to me.

Initials

_______ All amounts due for services billed by WELLNESS WORKS PHYSICAL THERAPY, LLC to a Workers' Compensation payor which was subsequently declared by my employer to be a non-eligible claim.

Initials

_______ All amounts due for claims submitted by WELLNESS WORKS PHYSICAL THERAPY, LLC to my insurance company and not paid by 60 days

Initials

Medicare and Workers Compensation Information

_______ I certify that the information I have provided to WELLNESS WORKS PHYSICAL THERAPY, LLC for payment under the Social Security Act (Medicare) or under the Workers Compensation Program is correct, including but not limited to any related accidents/illness or other insurers/payors available.

Initials

I, ______________________________, understand the statements I have authorized above and declare their truthfulness.

Printed Name

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Written Authorization for Use Required.

PAYMENT AUTHORIZATION

____ ______________

Patient or Authorized Representative for Patient Signature/Date Initials

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Written Authorization for Use Required.