MONIQUE KREBSBACH PHYSICAL THERAPY, INC

Patient Name (Last, First, MI) **Date of Birth**

Authorization for Treatment:
I hereby authorize and consent to the administration of all procedures that may be considered necessary or advisable for me or my dependent in the judgment of Monique Krebsbach, PT

Insurance Coverage:
Some insurance companies require pre-authorization and/or a referral prior to treatment. Failure to obtain the pre-authorization and /or referral may result in lower payment or claim denial from the insurance company.

I understand that if my insurance requires a prior authorization for treatment, it is my responsibility to see that one is obtained.

Assignment of Benefits:
I hereby assign to Monique Krebsbach Physical Therapy, INC all benefits which are or shall become payable by my medical plan or other liable insurance carrier (including Medicare, TRICARE, Workers' Compensation or other government programs), or from any third party, for any and all services furnished by Monique Krebsbach Physical Therapy, INC to me or my dependents for whom I am financially responsible.

In addition, I approve these payors and/or references to release information to: Monique Krebsbach Physical Therapy, INC

I understand that I will be financially responsible for any charges not covered by insurance.

Release of Information:
I hereby authorize Monique Krebsbach Physical Therapy, INC to use or disclose my own or my dependent's information for treatment, health care operations, and for payment and collection.

I authorize Monique Krebsbach Physical Therapy, INC to use or release necessary medical information to any insurance carrier, or other responsible third party, or their representatives, for the purpose of processing claims for payment for services rendered to me or my dependents.

I further authorize Monique Krebsbach Physical Therapy, INC to contact me at the telephone number(s) or address that I have provided, for the purposes related to the collection of the balances due.

Cancellations / No Shows:
If during the course of treatment, I cancel a scheduled appointment, I will notify Monique Krebsbach Physical Therapy, INC at least 24 hours before the appointment.

If I fail to give a 24-hour notice of cancellation, I understand that I will be charged $25.00 that is not billable to insurance companies. After 3 missed appointments, Monique Krebsbach Physical Therapy, INC reserves the right to discontinue services, as attendance is necessary to make any improvement.

Payment Agreement:

I understand that it is my responsibility to pay for all my charges, regardless of insurance or other third-party liability.

Out-of-pocket costs may be paid at the time of service by: **Cash, Check or Credit Card**

If you have not yet met your insurance deductible you will be required to pay $50.00 toward your balance at each visit.

I understand that I am expected to pay the balance due on my account each month unless other credit arrangements have been made. This applies even when services are ongoing.

Any account outstanding over 60 days will be assessed a 1% service charge each month thereafter.

We will be happy to discuss payment plans as necessary.

Monique Krebsbach Physical Therapy, INC is free to declare the entire balance to be due and payable if any scheduled payments are missed.

In the event any action is necessary by either party to enforce the covenants, right or obligations in this Agreement, it is agreed that the prevailing party shall receive payment for all costs, including reasonable attorney's fees.

I certify that I have read, understand and agree with the above statement. I understand that this authorization remains valid unless revoked in writing, and that a copy is as valid as the original.

_____

Patient Signature Date:

_____

Authorized Representative Signature Date:

_____

Relationship to Patient