OFFICE POLICY ON PAYMENT:
It is our policy to require payment of all office charges at the time they are given, unless prior arrangements have been specifically made.

We have calculated your **ESTIMATED** patient portion for each visit to be $____________ .
This is based off of the following information gathered from your insurance company:

Deductible: ___________ Deductible Met: ___________ Copay/Co-insurance: ___________
Visit Limitations: ___________ Authorization Required: N Y: ___________

The amount stated above will be collected from you before each visit. All additional amounts owed as patient responsibility will be billed to you each month in an itemized patient statement. All accounts over 60 days will be charged an interest rate of 1 1/2 percent per month (18% per annum) or a $2.00 minimum. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs charged by the collection company, which costs will not exceed 35% of said unpaid balance, including a reasonable attorneys fee.

It is also our policy to charge a $25 no show/cancellation fee for any missed visit scheduled and not cancelled at least 24 hours in advance.

INSURANCE POLICY:
Insurance provides for your reimbursement on allowed medical charges. We will submit to most insurance carriers, if you have provided us with policy numbers, address, place of employment and any other pertinent information. As a courtesy to you we can provide an itemized statement you may send to your insurance company for payment. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations, this is your responsibility.

You are responsible for all deductibles and charges not covered by insurance.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

CONSENT FOR CARE AND TREATMENT:
I, the undersigned, do hereby agree and give my consent for PROACTIVE PHYSICAL THERAPY to furnish medical care and treatment to (patient name) ________________________ considered necessary and proper in evaluating or treating his/her physical and mental condition.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS:
I authorize the Doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to me. I understand that this medical information may be used for any of the following purposes: diagnostic, insurance, legal, and at times when the Doctor deems it necessary in order to ensure the best medical care on my behalf. I further understand that any person(s) that receive these medical records will not release any of the medical information obtained by this authorization to any other person or organization without a further authorization signed by me for release of the information.

I have read the above and accept financial responsibility in full for this account.

SIGNED:____ **DATE:** _______________
Patient, Parent or Guardian