THERAPY WORKS

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby assign all medical benefits which I am entitled to TherapyWorks of Jacksonville, Inc. and any providers under this organization in the event they file insurance on my behalf. In the event that my insurance company forwards payment directly to me, instead of TherapyWorks, I will immediately deliver said payment to TherapyWorks. I understand and agree that insurance claims will be submitted to my insurance company as a matter of convenience only, and that I am responsible for all charges regardless of my existing medical coverage. I understand that I am responsible for all supplies, exercise bands, ointments, tape, braces or any other item which I am provided during treatment, if they are not covered by my insurance plan. I understand that I will pay for supplies upon receipt and TherapyWorks of Jacksonville, Inc. will bill my insurance company and refund me any monies received by them for said supplies.

I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of a debt. This includes but is not limited to collection service fees, attorney's fees and all court costs and additional legal fees associated with the recovery of this debt. Interest charges at a rate of 1.5% per month (18% annually) for unpaid balances over thirty days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original.

NOTIFICATION OF COPAY/ COINSURANCE / DEDUCTIBLE / SELF PAY

If you are using your insurance policy for payment of therapy services, your insurance policy requires the payment of co-payments and deductible amounts from you at the time of service. Your insurance company also requires TherapyWorks to collect your co-payment or unmet deductible amount or we would be in violation of our contract with your insurance company and risk not being reimbursed for your treatment process.

After verifying insurance coverage or a mutual self pay agreement for care, your responsibility is:
COPAYMENT $_____per visit X _____ COINSURANCE:$_____ DEDUCTIBLE: $_____
OTHER:_____

PAYMENT INFORMATION Relationship to Patient ◯Self ◯Spouse ◯Parent

Payor Type (Please Check)	◯ Auto/PIP	◯ Work Comp.	◯ Private Health Ins.	◯ MC	◯ Tricare	◯ Self

Plan Name	Claims Office Street Address	City	State	Zip Code

Claim or Case #	Insured's I.D#	Policy/Group #

Adjuster's Name	Phone #	Fax #	Date of Injury

SECONDARY INSURANCE If there is NO secondary coverage Initial Here ◯

Name of Insurance	Insured's ID / Policy / Group #	Claims Office Street Address and Phone Number

Payment will be expected at each visit unless other arrangements have been made: A credit card is required to be on file for all unpaid balances, no show and cancellation fees. Please complete below.

Credit Card Type:	Name on Card	Card #	Expiration Date

If Case in Litigation: Attorney Name	Address City State Zip	Phone #

Signature:_____Date:_____
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Internal use Only
Authoized by_____ Copay/Deduct$_____# of Visits_____ MC CAP_____