ASSIGNMENT OF BENEFITS/
ACKNOWLEDGEMENT OF CO-PAY

I, the undersigned, do hereby authorize and demand the assignment of all medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance, Workers Compensation insurance, and any liability settlement payments to Professional Therapy Services.

_____ Initial I, the undersigned, do acknowledge that I have been informed by Professional Therapy Services that there will be a $_____ co-payment, deductible, or co-insurance amount due for **each visit** and I agree to pay the required amount at the end of each visit. IF my insurance has a deductible, I understand I can make arrangements to pay what I can reasonably afford on each visit and will be billed the remainder after the insurance finalizes my claims. The amount I will agree to pay per visit is $_____.

I hereby authorize Professional Therapy Services to release all information necessary to secure the payment of said benefits. I understand that the benefits represented to me today are not a guarantee of payment by my insurance company. **I acknowledge I am ultimately responsible for all charges incurred and any balance remaining after insurance has paid.**

_____ Initial If your injury is work related, we will file all charges with your employer's insurance carrier. We will accept reimbursement from the carrier as payment in full for the treatment you receive.
If your employer does not accept responsibility for your injury, you will be asked to pay for the charges you incur at our clinic.

_____ Initial If your injury resulted in a litigation process, we must receive a letter of protection from the attorney who is representing your claim. After settlement is concluded, payment in full is due.
If your contract with your attorney is dissolved before your case is settled, you are responsible for all charges.

_____ Initial If you are a Medicare patient, we will file claims for your services directly with Medicare and any supplemental insurance that you may have. If you do not have supplemental insurance, you will be responsible for paying any unmet deductible and the 20% co-insurance.

_____ Initial We will bill your **secondary** insurance twice for payment. If we are unsuccessful in obtaining payment after these two billings, we will request your involvement in getting compensation from your **secondary** insurance.

RELEASE OF MEDICAL RECORDS

_____ I hereby authorize Professional Therapy Services to release information from my
Initial medical records related to treatment rendered to me during this episode of care. The purpose for releasing said information is to keep the physician, attorney, or insurance company aware of the progress being made.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ I acknowledge that PTS has their Notice of Privacy Practices/ HIPPA visibly
Initial posted in their lobby. I am also aware that at any time during this episode of care, I may request a copy and one will be provided to me.

I, the undersigned, have read and fully understand the Assignment of Benefits, Acknowledgement of Co-Pay, Release of Medical Records, Waiver of Liability, and Receipt of Notice of Privacy Practices that have been presented to me by Professional Therapy Services.

_____ _____

Signature Date

Patient/Parent or Legal Guardian

_____

Patient's Name (Print)

SOCIAL MEDIA AUTHORIZATION

_____ I hereby authorize Professional Therapy Services to use pictures and/or video on
Initial our social media platforms for teaching purposes only. I also authorize any written messages to be used as testimonials on social media.

How were you referred to PTS? ( ) Physician ( ) Attorney ( ) Yellow pages ( ) Relative
( ) Friend ( ) Insurance Provider Directory List
( ) Other_____