TEAM PHYSICAL THERAPY P.C.
Together Empowering Able Movement

INSURANCE AUTHORIZATION, RELEASE and FINANCIAL EXPECTATIONS

Patient Name:_____ Today's Date: _____

TEAM Physical Therapy, P.C. will file your claims to the insurance carrier that you provide. With your signature below you are authorizing your insurance company to pay directly to TEAM Physical Therapy, P.C. benefits otherwise payable to you, but not to exceed the clinic's regular charges for services provided. A current listing of all insurance carriers we are participating providers with will be posted or made available upon request for your review.

As a patient you are responsible to know what your physical therapy benefits include (deductible, coinsurance, visit limit, prior authorization, physician referral, etc.) Our Billing Team calls your insurance company the day after your first visit to review your physical therapy benefits. If you would like to visit with our Billing Team to learn more about your insurance benefits or get an estimated cost of your care please contact them at (308)872-5111 between 8 and 5 Monday – Friday. TEAM Physical Therapy, P.C. can NOT give you an exact cost of your care until your insurance has finished processing your claims. If a settlement or lawsuit is pending regarding your injury you will be responsible to make monthly payments on your account until the balance is paid in full.

Please read and answer each item below:

YES / NO I authorize TEAM Physical Therapy, P.C. to have Navicure Payment Services send electronic account billing statements/invoices to my provided email address on file. I understand that I will not receive a copy of any such invoice via US Mail. I understand that it is my responsibility to maintain a current email addresses on file and that this authorization will remain in effect until I provide written notice of cancellation. I understand that I can cancel the authorization only for future services. Authorization for services already rendered cannot be cancelled. I understand that my email will be kept private and not shared with any other person or business and will only be used for billing account and not advertising or other communications.

_____email (person responsible for account).

YES / NO I authorize TEAM Physical Therapy, P.C. to apply charges to my payment card, debit/credit card or bank account for all amounts owed during the course of this current treatment including; agreed upon monthly payment plan amounts, co-payments, coinsurances, amounts not covered by insurance, late fees, and appointment cancellation fees. I agree to notify TEAM Physical Therapy, P.C. in writing of any changes in my payment or address information. If yes: *Please complete Automatic Payment Authorization form if enrolling in our auto pay program.*

I understand I am responsible for payment of all services rendered on my (or my dependent's) behalf. I will keep my account current and settle any discrepancies with my insurance company personally. I understand any unpaid balance on my account (after the due date) will incur a 1.33% monthly late fee charge (16% annual) that will be added to my outstanding balance that I am also responsible for. Missed payments may lead to my account being released to a collection agency. Any checks that bounce from my account may be turned over to the county attorney for collection.

The undersigned has read and completed all the above information accurately.

Signed: _____ OR _____

Patient (must be 19) Authorized Person / Relationship

Date _____ Time: _____A.M. / P.M. Witness: _____