# Adams Physical Rehab & Spine Center, LLC

## Authorization For Care

I/we hereby authorize to receive care at Adams Physical Rehab & Spine Center, LLC (APRSC). I/we understand that receiving physical therapy may involve stress of musculoskeletal tissue that may cause soreness. Furthermore, I/we understand that the provider may need to perform mobilization technique, massage technique, manual traction, distraction, ultrasound, electrical stimulation, taping, bracing, orthotic fitting, weight training and other movement modalities that may produce brief soreness and discomfort. It is my/our responsibility to communicate any difficulties that I/we are having during treatment to my/our provider. It is also important to communicate any medical or activity changes that have occurred in my/our daily routine that may affect treatment decisions.

### Payment Policies

I/we understand we are responsible to pay all co-pays, coinsurance, deductibles and fees that are provided by APRSC. I/we understand that it is our responsibility to understand the percentage of coverage allowed by our insurance program and understand the coinsurance payments and deductibles that may be required.
INTEREST IN THE AMOUNT OF 1.5% WILL BE ADDED TO ALL BALANCES OVER 60 DAYS OLD.

## Assignment & Release

I/we understand the undersigned, assign directly to APRSC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I herby authorize the physical therapist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I also understand that if I have a co-pay it will be due at the time of service.

### Medicare Authorization (for Medicare Patients only)

I request that payment of authorized Medicare or Medigap benefits be made either to me on my behalf of APRSC for any services furnished to me by a physical therapist. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance or Medigap is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

(Signature of patient/parent or guardian) Date