



OPTIMUM CARE THERAPY
PHYSICAL THERAPY, CHIROPRACTIC SERVICES & SPORTS MEDICINE

Billing Policy, Release, Authorization, and Collections

I authorize Optimum Care Therapy to bill my insurance company directly for the covered portion of charges, and I authorize payment of benefits directly to Optimum Care Therapy. I authorize Optimum Care Therapy to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, co-insurance or co-payment, and any charges not reimbursed by my insurance carrier. In the event that I receive payments from the insurance company, I will forward the payments to Optimum Care Therapy. I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatments. I understand I am responsible for knowing and meeting the requirements of my insurance plan.

In the event I default on my account, my account will be turned over to your collection agency. If payment arrangements are not kept up on a timely basis and my balance becomes more than 120 days old, you will proceed to send my account to your collection agency. I understand that there is a 2% monthly interest charge if my account becomes past due and should my account be referred for collection or legal matters I will be responsible for a one time \$30.00 charge.

Name of patient _____ Date _____

Signature of patient/parent/legal guardian _____

Written Acknowledgment of Receipt of Notice of Privacy Practice

I have received the Notice of Privacy Practices and have had an opportunity to review it.

This Notice describes how my protected health information may be used and disclosed, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

Name of patient _____ Date _____

Signature of patient/parent/legal guardian _____

Privacy Practice is available on request. If you do not wish to receive a copy, please initial here. ____