ADVANCED PHYSICAL THERAPY and Sports Rehab
Therapy with a heart!

Authorization and Assignment Of Benefits

I consent to the release of my personal medical records by Advanced Physical Therapy and Sports Rehabilitation for the purpose or for necessary insurance purposes to the authorized representative of my insurance company.

I hereby authorize Advanced Physical Therapy and Sports Rehabilitation to carry out all procedures as ordered by my physician.

I authorize payment of benefits be made on my behalf to Advanced Physical Therapy and Sports Rehabilitation. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

I understand, unless the clinic agrees in writing to postpone collection of fees, all charges for goods and services provided to me shall be due and payable within 30 days of the date provided. Charges not paid within 30 days will be subject to interest charges of twelve percent (12%) per annum. If said charges are not paid in full and it becomes necessary to undertake collection efforts or legal steps to collection, then I will be responsible for the costs of collection, including court costs, reasonable attorney fees, and accrued interest.

Patient Signature (or Parent/Guardian Signature if applicable)	**Date**
Patient PRINTED Name	
Parent/Guardian PRINTED Name (if applicable)	

I hereby Authorize Advanced Physical Therapy and Sports Rehabilitation to contact the following individuals regarding my account/financial issues:

Name	**Relationship**	**Phone Number**
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