Breeze Physical Therapy and Wellness LLC

# Office Policies

All patients must recognize that they are responsible for the charges incurred for physical therapy. We will attempt to verify what your insurance benefits are. However, quotation of benefits from your insurance company does not guarantee payment. We will submit billing to your insurance company free of charge. In the event that your insurance carrier does not submit payment for services rendered, a statement will be issued to you for payment. We do request that you notify us 24 hours in advance if you are unable to attend a scheduled appointment. If you are 15 minutes late or greater, the therapist will have the option of seeing you or rescheduling. Checks that are returned for any reason are subject to a $10 service fee.

**Authorization and Assignment of Benefits:**

I hereby authorize and direct you, my insurance company, to pay directly to Breeze Physical Therapy and Wellness LLC such sums as may be due and owing this office for services rendered to me, both by reason of accident of illness, and by reason of any other bills that are due this office and withhold such sums from any disability benefits, medical payment benefits, no-fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me or from any settlement, judgment , or verdict on my behalf as may be necessary to adequately protect said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided. In the event my insurance company, obligated to make payments to me upon the charges made by this office for their services, refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to compromise, settle, or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the amounts due this office for their services. I further understand and agree that this assignment and authorization does not constitute any consideration for the office to await payments and they may demand payments from me immediately upon rendering services at their option. I authorize this office to release any information pertinent to my case to any insurance company, billing service, adjuster, or attorney to facilitate collection under this assignment and authorization.

**MEDICARE PATIENTS:** We bill our standard fees to Medicare, they pay 80% of their allowable fees, and the difference is billed to your secondary insurance. If you do not have a secondary insurance or your secondary insurance denies payment, you will receive a statement following the receipt of Medicare's allotment. Unless other arrangements are made, you will be responsible for the remaining 20% of the Medicare allowable rate. Other arrangements______________________________________________________________________

| ______________________________ | ______________________________ | ____________________ |
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| Printed Name | Signature | Date |