PHYSICAL THERAPY PROFESSIONAL CENTER, Inc.
17B Firstfield Rd, Suite # 105 Gaithersburg, MD 20878
Phone 301-990-1449
Fax 301-990-1016
email: info@ptpro.comcastbiz.net
web: www.physicaltherapyprocenter.com

FINANCIAL INFORMATION

PATIENT NAME: _____

ASSIGNMENT OF BENEFITS

I, _____, the undersigned, understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I authorize payment from my insurance carrier directly to this office with the understanding that all monies will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand the responsibility for any deductible, co-insurance or co-payment. I understand that any amounts charged by this office are owed by me irrespective of insurance. I also understand that fees for professional services rendered me will be immediately due and payable.
Any patient bill for services not paid within 30 days shall accrue interest at 1.5% per month. In the event of default or failure to pay any amounts due, I agree to pay collection costs, including reasonable attorney's fee. If this office shall pursue collection of amounts owed, I hereby agree to a waiver of any right to a jury trial.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Physical Therapy Professional Center, Inc. to release all medical or incidental information that may be necessary for either medical care or in processing application for financial benefit.

AUTHORIZATION TO USE SIGNATURE

I also authorize the use of this signature on all insurance submission.

STATUTE OF LIMITATIONS

In the event I am receiving treatment as a result of injures sustained in an accident for which I am pursuing a claim against a third party, I agree that any applicable statute of limitations on collection of any amounts owed to this office shall be extended to the greater of 3 years from: **1)** date of last treatment by this office or, **2)** resolution of the claim whether by judgment or settlement.

A photocopy of these assignments shall be valid as the original.

I certify that the contents of this form and all information given to Physical Therapy Professional Center, Inc. inclusive of insurance information, are accurate and correct.

_____ _____
PATIENT/ GUARANTOR SIGNATURE DATE