Peak Performance Therapy, LLC

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PPTCUS.com

Patient Agreement

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Peak Performance Therapy to request on my behalf and to collect directly all public and private insurance coverage due for products and services supplied by Peak Performance Therapy. In the event that benefits are paid directly to me, I will endorse to Peak Performance Therapy all checks for such payment.

EXTENDED MEDICARE ASSIGNMENT: I certify that the information given me under Medicare (Title XVIII, Social Security Act) and/or any other insurance is correct.

1. The Patient, if physically or mentally competent, must sign on his behalf. If he cannot sign for himself, a representative payee as designated by the Social Security Administration or a legally appointed guardian may sign. The source of the signatory's authority should be stated, e.g., Social Security Representative Payee, court appointed guardian, etc.
2. This form is used in lieu of the patient's signature on the "Request for Payment" HCFA-1500 form and is therefore an extension of that form. Anyone who misrepresents or falsifies essential information in making Medicare claims may, upon conviction, be subject to fine and imprisonment under federal law. Furthermore, in signing, the beneficiary authorizes any holder of medical or other information needed to process related Medicare claims. He further permits a copy of the authorization to be used in place of the original.
3. On assigned claims, the provider agrees to accept the Medicare Carrier's allowable amount as the full charge for covered services; the patient is responsible for the deductible, co-insurance and non-covered services. This authorization may be cancelled by mutual agreement of the provider and the patient at any time by written notice to the Medicare carrier. I request payment under the Medicare Insurance Part B of Medicare to be made directly to Peak Performance Therapy for services furnished to me during the effective period of this authorization. I have read and agree to the release of information as specified in paragraph 2 above.

MEDICAL CONSENT: **I give my consent for all routine, usual and customary tests, exams, and procedures as prescribed by the attending therapist of Peak Performance Therapy for: myself or my minor child or as legal guardian.**

RELEASE OF MEDICAL INFORMATION: I authorize Peak Performance Therapy to release any health care information necessary to facilitate processing of claims, audit of payments and routine professional medical communication with my referring and/or primary care physicians. Peak Performance Therapy maintains a record of health care services provided to you. You may ask to see and obtain copies of that record at any time. Peak Performance Therapy will otherwise not disclose your records or personal information to others unless you direct us in writing or unless required by law.

THE PATIENT HEREBY AGREES THAT HE/SHE IS FINANCIALLY RESPONSIBLE FOR ALL CHARGES RENDERED: I acknowledge that I am financially responsible for all charges. I have been given a copy of my estimated insurance benefits and Peak Performance Therapy's payment policy. If it becomes necessary to effect collections of any amount on this or any subsequent visits or procedures, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees and interest for overdue payments. I hereby acknowledge Peak Performance Therapy to release information necessary to secure payment of benefits or fees. **I also acknowledge that it is my responsibility to obtain a referral if my insurance company or HMO requires one.**

****Note: Peak Performance Therapy by law, cannot see a minor child or someone deemed unable to make decisions for themselves for treatment, without this document completed and signed prior to the initial evaluation.**

Print Name ____

Signature ____ Date ________________