Insurance and Financial Policy

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits, to which I am entitled to, including Medicare and other government sponsored programs, private insurances, and other health plans to Jersey Physical Therapy, LLC, who accepts this assignment.

I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only and that I am financially responsible for ALL CHARGES regardless of my existing medical coverage and whether or not they are paid by said insurance. **In the event that my insurance company forwards payment directly to me, instead of Jersey Physical Therapy, I will immediately deliver such payment to Jersey Physical Therapy Associates. I understand that these checks are payment to Jersey Physical Therapy for services rendered. X _______**
Initial

I understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any costs and or court fees, in addition to the outstanding balance.

JPT will bill patients on a monthly basis for the balance of charges not covered by their insurance company. We request payment of any balance due within sixty days of the date of the bill. After sixty days, balances due will be billed at a rate including an additional 1.5% interest fee per month. We accept payments in the form of cash, check, VISA and Mastercard.

I understand and agree that after 90 days if I have not paid my account in full, Jersey Physical Therapy will forward my account to an outside collection agency for processing. I agree to reimburse JPT the fees of any collection agency, which may be based on a percentage at a maximum of 40% of the debt, and all costs, and expenses, including reasonable attorneys' fees incurred in such collection efforts, in addition to the outstanding balance.

Release of Information

I hereby authorize Jersey Physical Therapy Associates, LLC to disclose or obtain any and all parts of my or my dependents records to or from any person or corporation which may be liable for all or part charges of Jersey Physical Therapy Associates, LLC. This includes but is not limited to, insurance companies, worker's compensation carriers or employers to secure said benefits.

I have read and understand the insurance/financial policy.

Signature: ____ Date: ____/______/_________

(Parent or Legal Guardian if patient is under 18)