Momentum Physical Therapy

Financial Agreement

Patient name: ____

I hereby authorize my insurance company to make payment directly to Momentum Physical Therapy for the professional or medical expenses allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. This payment shall not exceed my indebtedness to the above-mentioned assignee. I agree to pay, in a current manner, my balance of said professional service charges over and above insurance payment.

A photo copy of this assignment shall be considered as effective and valid as the original.

I agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I also understand that it is my responsibility to be aware of any limitations or special provisions of my policy.

I also authorize the release of information pertinent to my case to any insurance company, adjustor or attorney involved in this case.

I understand that if I write a personal check to Momentum Physical Therapy and it is returned for insufficient funds, there will be a $25.00 charge added to my account.

I also understand that I will be charged a $25 cancellation fee for any appointment that I fail to attend without 24 hours notice to Momentum PT. This charge will not be submitted to my insurance company but will be assessed directly to me

Signature of patient: _________________________________ Date: ____________

Signature of Parent/Guardian: _________________________________ Date:_________