Momentum Physical Therapy
Financial Agreement

Patient name: ____

I hereby authorize my insurance company to make payment directly to Momentum Physical Therapy 12640 S. Route 59 Unit 110 Plainfield, IL 60585 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 understand that if this course of treatment is related to a denied workman's compensation case, I may use my personal health insurance with documentation that my workman's compensation claim has been denied. However, I will be responsible for any deductible, co-insurance or copays to be paid in a timely manner.

I understand that if this course of treatment is related to an auto accident, I may provide my personal health insurance with documentation that my claim is handled by a third party payor and no payment is currently being made. However, I will be responsible for any deductible, co-insurance or copays to be paid in a timely manner. If I chose for my bills to be sent to the third party payor, I will have 2 years from my last date of treatment at this facility before payment is expected to be made. If I wish to have my claims sent to my personal health insurance at a later time, most require claims to be submitted within one year, some as little as 30 days. If claims are not submitted to my personal health insurance within their timely filing limits secondary to my not authorizing this office to do so, they will be denied and will be my responsibility.

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 Momentum no longer mails statements but send them via email. If no email is available when a statement becomes available, the statement will be mailed along with a $3 paper statement fee.

[enter email address] ____

I understand that if I fail to pay my statement in a timely manner I may be referred to a collections agency. If that is the case, a 25% fee will be added to my account to cover all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs.

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:_________
Printed name of Parent/Guardian _________________________________ phone: ____________________