Amelia Physical Therapy Permission Form

10130 Superior Way
Amelia, VA 23002

114 E. Broad Street
Blackstone, VA 23824

1. I am requesting Amelia Physical Therapy, Inc. to provide physical therapy services to me on behalf or as prescribed by my physician.

2. I authorize the release of any and all medical records that would be beneficial to the processing of this claim or to further my rehabilitation.

3. I request that payment of authorized insurance benefits for services be reassigned to Amelia Physical Therapy, Inc.

4. I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf.

5. I understand that it is my responsibility to pay for services and supplies if my insurance benefits are paid to me inadvertently.

6. I am requesting physical therapy services be provided to me and understand that it will be my responsibility to pay for these services if my insurance does not pay. Amelia Physical Therapy makes every effort to verify insurance coverage; however, I recognize that it is my responsibility to be aware of my policy details and limitations regarding outpatient physical therapy.

7. I understand that any balance remaining on my account after 60 days from the date of service is subject to interest charges at the rate of 1.5 percent per month.

8. I understand I am responsible for all registered mail fees, court costs, and attorney fees incurred as a result of collection efforts on this account.

9. I understand that I am responsible for a return check fee of $35.00 if payment made by my personal check is returned to Amelia Physical Therapy because of insufficient funds.

10. I am aware that a notice of Amelia Physical Therapy's Privacy Practices is posted in the waiting room and a copy is available upon request.

_____ **A $25.00 FEE WILL BE CHARGED FOR MISSED APPOINTMENTS WITHOUT 24**
(Initial) **HOURS NOTICE. Amelia Physical Therapy reserves the right to place you on "same day appointment only" list for future appointments after 3 cancelled visits or no shows.**

Patient Signature/or Responsible Party:_____Date:_____

Patient Printed Name: _____ Witness: _____

Please provide your email so we can send a survey at the end of therapy. Thank you!

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