PATIENT AUTHORIZATION FORM

Live Well Physical Therapy, LLC
623 River Road, Suite 5
Fair Haven, NJ 07704

I acknowledge that the information which I have provided on the patient information sheet is correct and true.

I hereby authorize my insurance company to make any payment for services rendered to me directly to Live Well Physical Therapy, LLC. Should any payments be made to me directly, I agree to turn these payments over to Live Well Physical Therapy, LLC immediately. I understand I am responsible for any portion of my bill not covered by my insurance carrier.

I hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself or my dependents. I permit a copy of this authorization and my signature to be used in place of the original.

I understand that many insurance plans have visit limits for physical therapy as well as pre-authorization requirements. It is each patient's responsibility to understand the extent and limitations of their individual insurance plans. I understand that if Medicare is my insurance carrier, they require that my treatment plan be reviewed and renewed by my referring physician every 30 days in order for physical therapy services to be covered. Please advise our staff if you are receiving any type of home care services. Medicare will not pay for outpatient physical therapy services until you have been discharged from home care.

I understand that I am fully responsible for all charges for services rendered as well as for costs incurred by Live Well Physical Therapy, LLC for return check fees or collection on my account.

I agree to make any plan mandated co-payments at the time of service for each visit.

If my insurance plan assesses coinsurance I agree to pay the full amount due as claims are processed and as I am billed by Live Well Physical Therapy, LLC.

I understand that if Live Well Physical Therapy does not participate with my insurance plan, I will be using my out of network benefits and will be responsible for any amounts not paid by my insurance plan.

I hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself or by dependents. I permit a copy of this authorization and my signature to by used in place of the original.

I authorize Live Well Physical Therapy, LLC to render physical therapy treatments to me.

Name (please print)

Signature:_____Date:_____