AUTHORIZATION FOR PAYMENT STATEMENT

I acknowledge that I am responsible for payment for all bills for services rendered to me by Advanced Physical Therapy Services, Ltd, d/b/a Advanced Rehab & Sports Medicine Services (ARSM). Any insurance that I have which can be used for reimbursement of these bills will be assigned to ARSM to the extent of any unpaid balance. In turn, ARSM will assist me in filing my claim with the insurance company. In the event of any dispute over the amount of insurance proceeds payable, I will pay ARSM, and then resolve the dispute with the insurer. I also understand that ARSM will furnish me facts and other pertinent information regarding my claim.

ARSM's Notice of Privacy Practices provides information about how they may use and disclose protected health information about you. You have the right to review the notice before signing this consent. As provided in the notice, the terms may change. If the notice is changed, the revised copy will be posted at the office. You may obtain a revised copy by contacting the office. You have the right to request that ARSM restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. ARSM is not required to agree to this restriction, but if they do, they are bound by this agreement. By signing this form, you consent to the use and disclosure of protected health information about you for *treatment*, *payment* and healthcare *operations*. You have the right to revoke this consent, in writing, except where disclosures have been made in reliance on your prior consent. If you do not sign this consent, or later revoke it, ARSM may decline to provide treatment.

Authorization is hereby granted to release to the respective Insurance Company (companies) and when applicable to the Social Security Administration and Centers for Medicaid and Medicare Services (CMS) or its intermediaries or carriers, (or to the billing agent or supplier), such information as may be necessary for the completion of insurance claims.

If I have co-insurance and/or unmet deductibles, I agree to pay the required portion per visit or at the beginning of the week until my treatment is complete or until the co-insurance and/or unmet deductibles have been met. <u>I understand that once my treatment is completed I am responsible for any remaining balance not covered by my insurance. If my insurance is Medicare or IPA, I will be responsible for any charges which exceed the treatment limits for each. If I fail to pay the remaining balance, ARSM may turn my account over to a collection agency or pursue legal action which may include court costs and attorney fees. I also understand that if my check returns for insufficient funds I may be charged a $20 fee.</u>

FOR PATIENTS ENTITLED TO MEDICARE BENEFITS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Advanced Physical Therapy Services, Ltd, d/b/a Advanced Rehab & Sports Medicine Services for any services furnished to me by that physician / supplier. I understand that there are financial limitations on my benefits imposed by CMS and that I can request a balance in writing at any time during the course of my treatment plan. I authorize any holder of medical information about me to be released to CMS and its agents any information needed to determine these benefits payable to related services

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated on the CMS Form UB-92 or elsewhere on other approved forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare Carrier as the full charge and the *<u>patient is responsible only for the Deductible, Co-Insurance and Non-Covered Services</u>*.