

The Healthy Back Clinic

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in the place of the original. Also, I hereby authorize Michael J Harmon to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to Michael J Harmon (or to the party who accepts assignment). I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date _____ **Signature:** _____

Patient, Parent or Guardian: (please print) _____

Please be advised that Medicare only pays 80% of approved charges for outpatient physical therapy services. Secondary or Supplemental policies usually cover the remaining 20% in most cases. If you do not have a secondary or supplemental insurance policy, you are responsible for the remaining 20% charges.

If you are not a Medicare patient and have another primary insurance company for coverage of medical services you are also responsible for payments of charges not covered by your insurance carrier. In either case we will inform you of your payment responsibilities as they relate to co-payments, deductibles or coverage in general for outpatient physical therapy services.

I _____ understand that I am responsible for payments of services not covered by my insurance company.