BRAUN
PHYSICAL THERAPY

I understand that Braun Physical Therapy is billing my insurance as a courtesy, and I hereby assign all physical therapy benefits directly to Braun Physical Therapy. I understand that most insurance companies, (including Medicare), pay only a certain portion of patient services depending on the policy. Should they deny my claim or any portion due, I am financially responsible and agree to pay for all the charges related to services provided to me at Braun Physical Therapy, regardless of the status of my insurance claim.

I request that payment of authorized Medicare benefits or other insurance benefits be made on my behalf to Braun Physical Therapy for any services furnished to me by Braun Physical Therapy.

I understand that my signature authorizes the release of my medical information to the insurance company, indicated in Item 9 of the HCFA-1500 claim form or elsewhere on other approved claim forms or electronically submitted claims. This information will only be disclosed to the insurance company once it has been requested and deemed necessary information that is needed to determine benefits payable to related services by the insurance company.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier. This authorization will remain valid until rescinded in writing.

I have read the above and fully understand the terms thereof.

Patient Name_____Date_____

Patient Signature _____Date_____

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