PERFORMANCE OVER PAIN
AUTHORIZATION FOR TREATMENT
INSURANCE AUTHORIZATIONASSIGNMENT
AND GUARANTEE OF ACCOUNT

I authorize treatment as deemed necessary by the therapist. I assign my insurance benefits directly to Performance Over Pain. I understand that unless my signature is affixed, claims cannot be submitted for me and I will be responsible for the charges at the time of service.

I hereby consent to the release of my medical records to the following persons: facility personnel, attending physicians and consultants; any person, firm, government entity, third party payor or managed care organization responsible for all and any part of the payment or reimbursement of the patient's charges, including any utilization review or quality assurance reviews or payment audits performed by such, the personnel of any hospital or any other health-care facility at which the patient may receive services, the facility's liability insurance carrier, and any person authorized by law to review the records.

The responsibility for insurance benefit verification rests with the patient. We will submit claims to the health insurance companies you have indicated, however cannot be held responsible for knowing your benefits. Patients are strongly encouraged to contact their health insurance companies directly as soon as possible in the treatment process to verify their therapy benefits. In order to maximize benefits, some contracts may require authorization / referral from a specific physician (most commonly a primary care physician), or may require treatment to be rendered by specific provider. Due to the ever increasing number of health insurance companies, creating, buying and selling network panels, and continually creating new health insurance products, we cannot be certain of network restrictions to which you may be subject, and cannot advise you on the nature of your benefits even when we know the name of your health insurance company. Furthermore, we cannot know what, if any, referral or authorization requirements your company may have designated for your policy. All patients are financially responsible for charges incurred regardless of health insurance coverage, and it is to the patient's benefit to become familiar with the limits of his / her insurance benefits as early as possible to facilitate informed treatment decisions.

Patient's signature: ____________________________________ Date: ___________
(Parent /Guardian if patient is a minor)

Witness signature: ______________________________________ Date: ____________

Office Use Only:

First Visit: **Diagnosis:** **Therapist:** **Witness:**

Version 2, 12/2013