PATIENT FINANCIAL POLICY AND AGREEMENT

We are committed to providing you with the best possible care. If you have insurance, we will gladly accept assignment of benefits and file all insurance claims provided verification of your insurance policies allows assigned benefits and coverage for the services rendered.
Please read the following statements carefully. By signing below, you agree that you have read and fully understand all statements contained herein.
I, the undersigned, understand that Elite Therapy Institute, LLC. will bill my insurance carrier for the services rendered upon verification of coverage from my insurance company. I also understand that should my insurance company fail to make payment for services rendered, I am fully responsible for all charges incurred, and will pay in full for all services. I understand that I am responsible for payment of any and all deductibles, and/or co-insurance amounts and the charges incurred are not subject to any fee schedule or reductions made by my insurance carrier. I also understand that if my treatment is due to an injury which results in litigation against a third party, this in no way relieves me of my obligation to pay for the services rendered. I understand that payment of the fees is not contingent upon settlement of a litigation; however, I hereby instruct my attorney to pay Elite Therapy Institute, LLC. in full, directly from the proceeds from any settlement or judgment rendered on my behalf.

EXPLANATION OF MEDICARE BENEFITS

Accepting assignment means that the provider of services agrees to accept the allowable charges as determined by Medicare as full payment. However, Medicare pays 80% if the allowable charges, therefore you are responsible for the 20% balance. In addition to the 20% you are also responsible for any amounts applied toward your annual Part B deductible and any non-covered charges.

SUPPLEMENTAL COVERAGE/CO-PAYMENT

Elite Therapy Institute, LLC. has explained to me that under Medicare guidelines, I will be responsible for the 20% of the allowable charge. As Elite Therapy Institute, LLC. has agreed to accept assignment of benefits on this portion of the charges also, I understand that should the supplemental insurance company fail to pay for these charges within a “reasonable length of time”, or send payment directly to me, I will become responsible for payment in full.

WORKER’S COMPENSATION COVERAGE

Elite Therapy Institute, LLC. agrees to treat and bill worker’s compensation for preauthorized work-related injuries per the Worker’s Compensation Guidelines for the State of Florida. However, if for any reason Worker’s Compensation denies liability for the treatment of the injury, I understand that I become responsible for full payment of the charges.

AUTHORIZATION OF TREATMENT AND ASSIGNMENT OF BENEFITS

I, the undersigned, hereby consent to such treatment by the authorized personnel of Elite Therapy Institute, LLC. as may be dictated by prudent medical practices

of my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

The undersigned certifies that the information given by me in applying for payment under the Title XVII of the Social Security act is correct. I, the undersigned, authorize Elite Therapy Institute, LLC. to release information regarding m health care to the Social Security for this or a related claim. I authorize payment from Medicare to be made directly on my behalf.

I hereby instruct and direct that _____, my Supplemental/Commercial Insurance pay by check made out and mailed to:

Elite Therapy Institute, LLC.
8190 S Jog Rd. Suite 100
Boynton Beach, Florida 33472

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment is not to exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay any balance of the said professional service charges over and above this insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

_____ _____
Signature of Policy Holder Date

_____ _____
Signature of Claimant, if other than Policy Holder Date

_____ _____
Witness Date