Balance and Neurologic Center of the Rockies
Specializing in Neurologic Physical Therapy
Jaimy Wahab, PT, DPT, NCS
5387 Manhattan Circle, Suite 100A
Boulder, CO 80303
P: 303.929.2950 F: 303.362.5734

PATIENT AUTHORIZATION AND GUARANTEE

CONSENT OF TREATMENT----------
I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of Balance and Neurologic Center of the Rockies.

INITIALS: _____

CHARGES & PAYMENTS ----------
We will file your physical therapy claims with your insurance company. All patient portions are due at the time of service. This includes copays, deductibles, co-insurance, etc. Cash, Check, are accepted. There will a $40 fee for returned checks. In some instances, insurance companies will not pay us directly for services rendered. In these situations, you are responsible for payment. You will be billed by Balance and neurologic center of the rockies, LLC. Interest will be added on all charges not paid in full within 30 days from the date they are rendered at the rate of 1.5% per month (18% APR).

INITIALS: _____

INSURANCE PAYMENTS----------
As a courtesy to our patients we will try to verify your insurance benefits when able. **This is not a guarantee of benefits**. *Please refer to your employer's policy manual or contact your insurance carrier if you have questions pertaining to your coverage.* **Please note that all disputed or pending claims will immediately become your responsibility.** In an event that a credit balance should reflect on your account due to insurance or patient payment, we will hold any refund until the account has been paid in full. If your insurance company HAS NOT paid us within 45 days the account will be billed to you, and it becomes your responsibility to pay us. You will then need to work with your insurance company for reimbursement to you.

INITIALS:_____

MEDICARE----------

I hereby certify that the information given by me in applying for payment under title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance. As of January 1, 2013 Congress extended the Cap on Outpatient Physical Therapy Services to $1,900/ year.

INITIALS: _____

ASSIGNMENT OF INSURANCE BENEFITS----------

I hereby authorize that the payment of authorized benefits be made directly to Balance and Neurologic Center of the Rockies for any services that are reimbursable by Medicare or any third party sources.
INITIALS: _____

CANCELLATION/NO SHOW POLICY ----------
Balance and Neurologic Center of the Rockies takes the subject of canceling your appointment very serious as it can make a difference as to whether you recover from your injury or condition. Showing up as scheduled is one of your most important responsibilities as a patient. **We require a 24 hour notice for the cancellation of a scheduled appointment. You will be charged $40.00 for a no-show or cancellation without 24 hour notice.** This charge will not be covered by your insurance and will have to be paid by you personally.
INITIALS: _____

_____
Patient Name

_____
Legal Guardian's Name (for patients under 18 years of age)

_____ _____
Signature **Date**