ASSIGNMENT OF PROCEEDS

I hereby agree to an assignment of proceeds of any monies received by me or on my behalf with respect to this injury/illness. This includes, but is not limited to, any settlement, claim, judgment, verdict or partial settlement, which occurs with respect to such accident/illness. I further authorize and direct you, my insurance company carrier, third party insurance carrier, and attorney to pay directly to Craven Physical Therapy & Spine such sums as maybe due and owing him for services rendered me, and to withhold such sums from any settlement, (either full or partial) claim, judgment, or verdict as may be necessary to protect him adequately.

FINANCIAL RESPONSIBILITY

I understand my co-payment is due and payable at time of service. I understand that I am directly, completely, and fully responsible to Craven Physical Therapy & Spine for physical therapy bills submitted for services rendered me, and that this agreement is primarily for Craven Physical Therapy & Spine additional protection beyond and lien being filed or financial responsibility being served and in consideration of his awaiting payment.

Should my account exceed 60 days without insurance payment I agree to pay my account in full or request a meeting with Craven Physical Therapy & Spine to extend credit at which time I agree to make monthly payments. The payment amount will be determined at that time.

WORKERS' COMPENSATION CLAIMS

If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

COLLECTION PROCEEDINGS

Should my account become delinquent I will be responsible for additional expenses to collect on my account including reasonable legal fees, collection costs, and other expenses reasonably incurred.

RELEASE OF INFORMATION

I authorize the release of any medical information necessary to process my claim to payers I have listed and to my physician and others providing health care to me. All other requests for release of medical information will require my express consent unless the law authorizes or compels Craven Physical Therapy & Spine to do so.

I understand Craven Physical Therapy retains a record of the health care services provided me and I can exercise my right to review the records or obtain more information and copy my records upon written request for a fee of $10.00. I also understand I can request amendment be made to the record.

NOTIFY OF CHANGES

I will notify Craven Physical Therapy & Spine of any changes in address, employment, or attorney representation within 10 days of the change.

AUTHORIZATION TO TREAT

I authorized Craven Physical Therapy & Spine to render physical therapy to myself/child or person to whom I am legal guardian.

Signature ____ Date ______________