BACK TO NORMAL
PHYSICAL REHABILITATION

FINANCIAL RESPONSIBILITY

_____ Back To Normal will verify your insurance benefits and communicate to you what the insurance representative states to be your benefits. All insurance companies state "Verification of Benefits and Authorization of Services are **NOT** a **Guarantee of Payment**". I understand and agree.

_____Back To Normal will file each claim to your health insurance company and use our best efforts to obtain payment. We will notify you of any issues with your insurance company. Any claim that your insurance company has not paid within 90 days from the date of service will become your financial responsibility. All amounts will be due and payable within 30 days from the date you are billed. I understand and agree.

_____If Back To Normal receives a request **at any time** from your insurance company to recoup any payment made on your account, we will notify you immediately. If your insurance company does not overturn their decision to recoup the payment(s), the financial responsibility will be transferred to the patient. I understand and agree.

ASSIGNMENT OF BENEFITS:

- **I hereby** instruct and direct my Insurance Company to make payment to: Back To Normal Physical Rehabilitation, and mail payments to 4795 Freedom Rd, Houma, LA 70360.
- If my current policy prohibits direct payment to provider, I hereby instruct and direct you to make out the check to me and mail it as follows: Back To Normal Physical Rehabilitation, 4795 Freedom Rd, Houma, LA 70360, for 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 will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

- A photocopy or fax transmission of this Assignment shall be considered as effective and valid as the original. I authorize this provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

- I grant permission for my physician to release my medical records to Back To Normal. I hereby authorize Back To Normal Physical Rehabilitation to release any medical information necessary to process any of my insurance claims. This authorization will remain in effect until revoked by me in writing.

I have read and understood the statements contained herein and I agree to the **Financial Responsibility** and **Assignment of Benefits** to Back To Normal.

Patient Signature: Date: _____ Time: _____
(or Guardian)

Print Patient Name: _____

4795 Freedom Rd, Houma, LA 70360 985-857-9097