AUTHORIZATION TO PAY

I authorize payment from my insurance company directly to Elite Performance Physical Therapy, P.C. for services rendered. I understand that I am financially responsible for those charges not paid by my insurance company including deductibles and co – payment. This is in accordance with the rules and regulations of my insurance company.

I am also responsible for obtaining all referral forms, prescriptions and letters of medical necessity required in order to obtain services in this facility.

Patient's Name_____ Date _____

Patients Signature _____

Parent or Guardian Signature _____
(If patient is under 18 years of age)