

**GENERAL OFFICE INFORMATION/PERMISSION TO TREAT**

Welcome to Lakeside Physical Therapy and Life Enhancement Center, LLC. We look forward to serving your physical therapy needs and wish you a speedy recovery.

**Billing Policy:** Our billing department will make every possible effort to accurately submit claims to your insurance company. In order to process your claims, we require referrals, insurance cards, and other necessary paperwork to be brought at the time of your appointment. Any balances following insurance processing will be computed according to the policies and contractual obligations of the insurance company and will be mailed to you each month in statement format. Payment is expected upon receipt. Should there be questions or concerns regarding your statement, please contact the billing department at your earliest convenience.

The contract you have with your insurance company is between **you and your insurance company**. It is **not** between you and Lakeside Physical Therapy, or between your insurance company and Lakeside Physical Therapy. Though we make every effort to comply with requests from your insurance company, ultimately, you are responsible for payment of therapy services.

Please understand that payment for medical supplies is due in full at the time of treatment. Also payment for durable medical equipment is due in full prior to receipt of the equipment unless prior arrangements have been made.

**I have read the GENERAL OFFICE INFORMATION and agree to its terms, and give Lakeside Physical Therapy and Life Enhancement Center, LLC permission to provide me with physical therapy treatment.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_ Patient named above is a minor, \_\_\_\_\_ years of age

**AUTHORIZATION AND ASSIGNMENT OF BENEFITS**

I, \_\_\_\_\_, hereby authorize Lakeside Physical Therapy and Life Enhancement Center, LLC to apply to (ins. company name) \_\_\_\_\_, for benefits on my behalf for services rendered by Lakeside Physical Therapy and Life Enhancement Center, LLC and request that the payments be made directly to them. I certify that the information I have reported about my insurance coverage is correct. I also authorize Lakeside Physical Therapy and Life Enhancement Center, LLC to release all necessary information, including medical information for this and any related claim, in order to determine benefits to which I am entitled. I permit a copy of this authorization to be used in place of the original. Furthermore, I understand that I am ultimately responsible for the services rendered.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**