AUTHORIZED TO TREAT AND ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO PROMOTION THERAPY, INC. PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE.

Patient: _____

I HEARBY AUTHORIZE PROMOTION THERAPY, INC. TO PROVIDE PHYSICAL THERAPY TREATMENT AS INDICATED BY MY PHYSICIAN.

I hereby instruct and direct_____ Insurance Company to pay any of my charges by check payable to Promotion Therapy, Inc. and mailed directly to our centralized billing office, 434 N. Washington Street, Suite 3, Millersburg, Ohio 44654.

If my current policy prohibits direct payment to the above company, then I request and instruct the above insurance company to send any check made payable to me for these charges to be sent to our centralized billing office, 434 N. Washington Street, Suite 3, Millersburg, Ohio 44654.

I understand that this is a direct assignment of benefits or rights I have or may have under my insurance policy. A copy of this agreement shall be as valid as the original. I hereby authorize Promotion Therapy, Inc. to release any medical or other information that may be necessary to process medical claims on my behalf to related physicians, rehabilitation counselors, insurance companies, adjuster or attorney involved in the case.

I understand that my insurance may not pay any or all of the costs of services rendered to me by Promotion Therapy, Inc. I agree to be personally responsible for the payment in full of any bills from or debt owed to Promotion Therapy, Inc. for services or treatment rendered to me or on my behalf. In the event Promotion Therapy, Inc. is not promptly paid, then I agree that a service charge of 1% per month may be added to the amount owed after any such amount is over 60 days past due. I further agree that if Promotion Therapy, Inc. files suit to attempt to collect any amounts owed, then I agree that their attorney fees and costs shall be added to the amount owed and/or judgment in addition to the service charge outlined.

_____

Patient Signature (if under 18, Signature of Parent or Guardian) Date

_____

Signature of Policy Holder, if different from patient Date

_____

Witness Signature Date