



Patient Name: _____ Date of Birth: _____

ASSIGNMENT OF INSURANCE/RELEASE OF INFORMATION

I authorize treatment of the person named above and agree that I am financially responsible for all charges incurred through this office, regardless of insurance or third party liability and that all proceeds of insurance are assigned to this office. I also request payment of government benefits either to myself or to the third party who accepts assignment. I authorize Willow Creek Physical Therapy/Victor Physical Therapy, Inc. to provide health care information concerning my medical condition to my insurance company or third party payer. The above information is for the purpose of extending credit and is warranted to be true.

Patient/Responsible Party Signature: _____ Date: _____

NO INSURANCE ACCOUNTS

Prompt payment allows us to control cost. Outstanding accounts cost us both time and money; therefore, all patients will be required to establish financial agreements for payments of their account. Payment is due at time of service.

There will be a \$30.00 fee for any returned checks. I understand that should I default from this agreement I will be liable for any court, attorney, or collection fees resulting from this default, in addition to my balance. All accounts must be paid in full within 90 days of billing to avoid collections.

I have read and understand the above information.

Patient/Responsible Party Signature: _____ Date: _____