Advanced Physical Therapy and Rehabilitation Center, LLC

Patient Registration Form

ALL PATIENTS PLEASE READ AND SIGN THE FOLLOWING AUTHORIZATON

I hereby authorize Advanced Physical Therapy to release such information as required by my insurance company/attorney in order to secure my insurance benefit. I also authorize my insurance company to pay Advanced Physical Therapy directly for services that they agree to bill for me. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

Advanced Physical Therapy's policy is that payment is due when services are rendered. A $25 fee will be assessed for all returned checks. I also understand that if this account is not paid in a timely fashion, that I will be responsible for any collection/and or reasonable attorney fees incurred in the attempt to collect this debt.

I am aware that I am ultimately responsible for all services charged to me and I understand that these services are to be paid in a timely fashion regardless of any insurance companies with which I may participate with.

THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Signature:______________________________________Date:___________

Parent or Guardian Signature:___________________________________Date:______________
(if under age 21, and adult must sign.)