PEDIATRIC THERAPY SERVICES | where children learn and leap

Insurance Authorization and Assignment of Benefits

I hereby authorize Pediatric Therapy Services, Inc. to furnish all information to insurance carriers and/or Medicaid concerning (Patient's Name) _____ diagnosis and or treatments. I hereby assign to PTS, Inc. (providers) all payments for therapy and related services rendered to my dependents.

Should the insurance company send payment directly to me, I will endorse said check over to Pediatric Therapy Services, Inc. (Initial) _____.

I understand that I am responsible for any amount not covered by insurance: this includes any course of treatment that is not a covered benefit, including DME products. (Initial)_____.

I understand that I am responsible for notifying Pediatric Therapy Services, Inc. of any changes in my insurance coverage. (Initial)_____.

If I am delinquent in updating this information and charges are denied, I understand that I am responsible for these charges. (Initial)_____.

I understand that I may be charged 1.5% interest rate per month on any unpaid balance and that I am responsible for any costs incurred in collection of said balance should that become necessary. (Initial)_____.

I understand that I will be charged a $25 fee for "No Show" appointments. (Initial)_____.

I authorize Pediatric Therapy Services, Inc. to initiate a complaint to the Insurance commissioner for any reason on my behalf. (Initial)_____.

I give my consent for Pediatric Therapy Services, Inc. to appeal claims to my insurance company on my behalf. (Initial)_____.

I give my consent for Pediatric Therapy Services, Inc. to appeal authorizations to my insurance company on my behalf. (Initial) _____.

My signature below indicates that I am the legal guardian of this patient and that I understand and accept this policy.

Printed Name: _____Relationship to patient: _____

Signature:_____Date:_____

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