FINANCIAL RESPONSIBILITY
I understand that my copayment is due and payable at the time of service. I understand that I am directly, completely, and fully responsible to Buffalo-Niagara Physical Therapy for physical therapy bills submitted for services rendered to me. Also, that this agreement is primarily for Buffalo-Niagara Physical Therapy additional protection beyond a lien filed or financial responsibility being served and in consideration of awaiting payment.

Should my account exceed 60 days without insurance payment, I agree to pay my account in full or request a meeting with Buffalo-Niagara Physical Therapy to extend credit at which time I agree to make monthly payments. The payment amount will be determined at that time.

WORKERS COMPENSATION CLAIMS
If you claim Workers Compensation Benefits and are subsequently denied those benefits, you may be held responsible for the total amount of charges for services rendered to you.

COLLECTION PROCEEDINGS
Should my account become delinquent, I will be responsible for additional expenses to collect on my account including reasonable legal fees, collection costs, and other expenses reasonably incurred.

ASSIGNMENT OF PROCEEDS
I hereby agree to an assignment of proceeds or payments to Buffalo-Niagara Physical Therapy that are received by me or on my behalf with respect to my care at Buffalo-Niagara Physical Therapy. I further authorize and direct you, my insurance company carrier, third party insurance carrier, attorney to pay Buffalo-Niagara Physical Therapy such sums as may be due and owing for services rendered me, and to not withhold such sums for any settlement (either full or partial) claim, judgement, or verdict as may be necessary.

RELEASE OF INFORMATION
I authorize the release of any medical information necessary to process my claim to payers I have listed and to my physician and others providing healthcare to me. All other requests for release of medical information will require my express written consent, unless the law authorizes or compels Buffalo-Niagara Physical Therapy to release this information.
I understand Buffalo-Niagara Physical Therapy retains a record of the health care services provided me and I can exercise my right to review the records or obtain more information. A copy of my records can be obtained upon written request for a fee of $15.00. I also understand that I can request amendments be made to the record.

NOTIFY OF CHANGES
I will notify Buffalo-Niagara Physical Therapy within 10 days of changes in my medical insurance, Worker's Compensation insurance , or No Fault insurance.

AUTHORIZATION TO TREAT
I authorize Buffalo-Niagara Physical Therapy to render physical therapy to myself/child or person to whom I am legal guardian.

Signature_____Date_____