



Neuromuscular Therapy • Pelvic Floor Pain & Rehabilitation • Orthopedic Rehabilitation

Authorization to Pay Benefits to Colorado Center for Physical Therapy

I authorize the release of medical or other information necessary to process health insurance claims. I agree to request payment of benefits to my provider, Colorado Center for Physical Therapy when they accept assignment.

I hereby agree to pay the deductible, percentage (co-pay) not covered by my insurance company as services are rendered. If for any reason a balance is owing on my account, I agree to pay that promptly upon receipt of the statement.

Although I have requested Colorado Center for physical Therapy to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure that the bill is paid in a reasonable amount of time. If for any reason any portion is not paid by my insurance company, I agree to make arrangements for prompt payment of the bill in full. Interest shall accrue on the unpaid balance at the rate of 18% per annum (1.5% per month).

I further understand, that in the unfortunate event my account is assigned for collection, I agree to reimburse Colorado Center for Physical Therapy the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorney fees, we incur in such collection efforts.

Signed _____

Date _____

Authorization to Release Medical Information

I hereby authorize my provider Colorado center for Physical Therapy to release any information required of my insurance company to process billing.

Signed _____

Date _____



Advanced Spine Strengthening • Therapeutic Massage • Rehabilitative Pilates • Pilates Reformer Classes