PATIENT AUTHORIZATION AND GUARANTEE

****IMPORTANT: PLEASE READ THIS CAREFULLY*****

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize that the payment of authorized benefits be made directly to FitLife for any services that are reimbursable by Medicare, Medicaid, or any third party sources.

VALUABLES

I hereby understand the FitLife is not responsible for valuables and personal property brought to the facility.

CONSENT OF TREATMENT

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of FitLife.

GUARANTEE OF ACCOUNT

In consideration of services rendered to me by FitLife, I hereby guarantee payment for any and all services rendered to me in which are not covered or allowable by insurance, together with collection costs, including reasonable attorney fees. I understand that there may be a charge for supplies that are needed during my course of treatment that will not be covered by my insurance and for which I am financially responsible. I also understand that I may have co-payment, co-insurances and/or deductible which I am fully responsible for paying. Although FitLife will inform me of my insurance coverage for physical therapy, it is ultimately my responsibility to understand my insurance benefit limitations and payment. I will immediately notify FitLife of any changes in my insurance coverage while receiving physical therapy.

MEDICARE

I hereby certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or a related Medicare Claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance.

I, _____, by signing this document, acknowledge my consent to the above:
(Print Name)

Signature: _____ **Date:** _____