How did you find out about Mortland Physical Therapy & Sports Medicine, LLC.?

☐Your Doctor ☐Family ☐Newspaper
☐Other Patient ☐Friend ☐Insurance Company
☐Yellow Pages ☐Other_____

Who is your Doctor? _____

Have you had physical therapy at another facility within the last 12 months? ☐Yes ☐No
If yes, where? _____ How many visits? _____
(If you have received the maximum number of physical therapy visits under your benefit year plan, prior authorization must be obtained before receiving physical therapy services in order for these services to be covered by your insurance company. You are responsible for providing accurate information to Mortland Physical Therapy & Sports Medicine for previous physical therapy services rendered. Failure to do so will result in your claim being denied by your insurance carrier and you will be responsible for payment of these services.)

It is your responsibility to know your insurance plan coverage for physical therapy services. You will be responsible for all unpaid balances on your account. Mortland Physical Therapy & Sports Medicine, LLC. will not be held responsible for any amount not paid by your insurance company.

In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance earner. I, authorize Mortland Physical Therapy & Sports Medicine, LLC. to furnish complete information to my insurance carrier or its intermediaries regarding the services rendered.

I, _____ hereby authorize Mortland Physical Therapy &
Patient Signature
Sports Medicine, LLC. to submit a claim to my insurance carrier or its intermediaries for all services rendered and authorized and direct my insurance carrier or its intermediaries to issue payment(s) directly to Mortland Physical Therapy & Sports Medicine, LLC.

FINANCIAL RESPONSIBILITY

I, _____ understand I am financially responsible for, and will
Patient signature
be billed for by Mortland Physical Therapy & Sports Medicine, LLC, any balances remaining on my account which are unpaid by my insurance carrier, i.e., co-pays co-insurance, and deductible not met, etc.

Any clarification needed regarding the above, should be addressed before signing this form