Monmouth Schroth Scoliosis Physical Therapy Patient Insurance Authorization

If your insurance plan has out of network benefits you should be eligible for reimbursement at their standard out of network rates. Most insurances will typically reimburse 70-80% of our billed charges after you have met your deductible.

As a courtesy, Monmouth Schroth Scoliosis Physical Therapy will not collect the full amount at the time of visit as the insurance companies suggest we do. Instead, we will bill the insurance company and wait for payment. Often the insurance companies mail checks and the explanation of benefits directly to your home. We will receive the information that you have been paid. We require that you endorse the check, but you do not have to cash it. Just bring it in along with the explanation of benefits to your next visit or mail it to us.

Please check the box and sign at the bottom:

___ I understand that I am responsible for bringing in all checks sent to me by my insurance company for services rendered.

___ I understand that I will be financially responsible if I deposit or cash checks meant for services rendered by Monmouth Schroth Scoliosis Physical Therapy.

___ I understand that I will be responsible for a cancellation fee of $100.00 if I do not cancel an appointment with 24 hours of the scheduled visit.

___ I authorize the release of any medical information to the insurance company necessary to pay the claim.

I have read and agree to all the above policies.

Parent/Guardian Signature:_____ Date:_____

Consent for Care and Treatment

I,_____, authorize Monmouth Schroth Scoliosis Physical Therapy to furnish medical care and treatment that is necessary and proper in the diagnosis and treatment of my /my child's physical condition. I understand this authorization shall be valid until I revoke the agreement in writing.

Patient's Name:_____

Patient/Parent/Guardian signature_____ Date:_____