

***Grand Central Physical Therapy
Grand Central Hand Therapy Center***

Insurance Reimbursement Agreement

Our Administrative staff will work with you and your insurance carrier to co-ordinate your care and ensure proper and timely reimbursement of all claims. Grand Central Physical Therapy and the Grand Central Hand Therapy Center will be referred to below as the “Center”. Please review the following and initial and sign where indicated. Thank you.

- I agree to supply the Center with all of my current Insurance Carrier’s information and will inform the Center of any changes, additions or terminations to my plan in a timely manner.
_____ Initial
- In the event that my Insurance Carrier does not make the expected and verified payment I understand that I am responsible for all incurred charges and agree to make a payment agreement with the Center to cover those charges. _____ Initial
- I authorize the release of any medical or other information necessary to process an outstanding claim for service. _____ Initial
- I authorize payment of insurance benefits to be paid directly to the providers at the Center.
_____ Initial
- In the event that my Insurance Carrier does not remit assigned benefits directly to the Center I understand and agree that I will be fully financially responsible for those payments. I also agree to forward any payments I receive from my Insurance Carrier for our services within 10 days of receipt. Insurance payments not forwarded to the Center will be subject to interest after 10 days. _____ Initial
- I understand that I will be charged a \$50.00 fee for missed appointments or for appointments cancelled with less than 24 hours notice. If a Late Cancelled appointment is made up within the same week the \$50.00 fee will be waived. _____ Initial

Signed: _____ **Date:** _____