Big Gym Therapy
Less like work. More like fun.

FINANCIAL AGREEMENT

On behalf of my child, _____ hereinafter referred to as the "Client,"
Client's name

I agree to promptly pay the account of Big Gym Therapy, LLC in accord with the regular rates and terms of the practice. I understand that the physical therapy services provided to Client hereunder are rendered and charged to the Client and not to the insurance company. I acknowledge that Big Gym Therapy, LLC neither guarantees nor warrants that such services will be covered by insurance. I assume the risk that such services may not be covered by insurance. I accept responsibility for all deductibles, coinsurance, and non-covered portions of services performed. Big Gym Therapy, LLC cannot accept total responsibility for collection for the claim nor for negotiating a disputed settlement. I understand that I am financially responsible for all charges incurred in the Client's treatment and care provided by Big Gym Therapy, LLC and that I am financially responsible for any amount not covered by the Client's insurance plan.

I understand that if my child is a Medicaid beneficiary and coverage has been terminated or suspended, and therapy services continue, I am financially responsible for all charges. In addition, my child's referring physician MUST BE ENROLLED in the Georgia Medicaid Program for Medicaid to cover therapy services or I will be responsible for all therapy charges.

Signature Parent/Guardian _____ Date _____

Printed Name _____

Relationship to Client _____

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE INFORMATION

On behalf of my child, _____ hereinafter referred to as the "Client,"
Client's name

I hereby authorize payment of insurance benefits directly to Big Gym Therapy, LLC, the health insurance benefits otherwise payable to me, for any services furnished to Client by Big Gym Therapy, LLC. I also authorize Big Gym Therapy, LLC to release to Client's insurance company or their agent, any information concerning treatment of the Client necessary for evaluating and administering claims of benefits. This assignment shall remain valid until written notice is given by me.

Signature Parent/Guardian _____ Date _____

Printed Name _____

Relationship to Client _____