



Moffett Physical Therapy, Inc.  
10389 Vine Street  
Huntley, IL 60142

I hereby authorize Moffett Physical Therapy, Inc. to furnish information to insurance carriers concerning illness or accident and treatment, and I hereby assign to Moffett Physical Therapy, Inc. all payments for medical services rendered to my dependents or me.

I understand that I am financially responsible for any amounts not covered by my insurance carrier, which includes amounts applied to my deductible, coinsurance, denied services, or charges deemed over “reasonable and customary.”

I understand that I need to give 24 hours notice when canceling an appointment, or I will be charged for that appointment.

I authorized the release of my medical records to the agents of Moffett Physical Therapy, Inc. and/or agents so indicated by myself.

\_\_\_\_\_  
Signature of Patient or Legal Guardian, if Patient is a Minor

\_\_\_\_\_  
Date

**MEDICARE PATIENTS ONLY**

I request that payment of authorized Medicare benefits be made on my behalf to Moffett Physical Therapy, Inc., for any services furnished to me by that provider. I authorize any holder of medical information regarding my patient care to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

I understand that I need to give 24 hours notice when canceling an appointment, or I will be charged for that appointment.

I authorized the release of my medical records to the agents of Moffett Physical Therapy, Inc. and/or agents so indicated by myself.

\_\_\_\_\_  
Signature of Medicare Patient

\_\_\_\_\_  
Date