1. RELEASE OF INFORMATION – I, the below named patient, do hereby authorize any therapist/provider examining and/or treating me to release to any third payer (such as an insurance company or governmental agency, example: Blue Shield of Rochester or Medicare) any medical information and/or records concerning diagnosis and treatment when requested by such third party for its use in connection with determining a claim for payment for such treatment and/or diagnosis.

2. THERAPIST INSURANCE ASSIGNMENT - I, the below named subscriber, hereby authorize payment directly to any therapist/provider examining or treating me of any group and/or individual therapeutic and/or medical benefits herein specified and otherwise payable to me for their services as described but not to exceed the reasonable and customary charge for these services.

3. MEDICARE/MEDICAID - Patient's certification authorization to release information and payment request. I certify that the information given by me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Social Security Administration/ Division of Family Services, or its intermediaries or carriers regarding any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the therapist/provider treating me.

4. I PERMIT A COPY OF THESE AUTHORIZATIONS AND ASSIGNMENTS TO BE USED IN PLACE OF THE ORIGINAL, WHICH IS ON FILE AT THE THERAPIST'S / PROVIDER'S OFFICE. This assignment will remain in effect until revoked by me in writing.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the therapist/provider and is not a substitute for payment. Some insurance companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **I understand that it's my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third party payer within a reasonable period of time not to exceed 60 days.**

If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

MEDIGAP (SECONDARY INSURANCE)

I request payment of authorized MEDIGAP benefits be made on my behalf to Freedom Therapy, OT, PT, SLP, PLLC **for any services furnished to me by the therapist / provider. I authorize any holder of medical information about me to release any information needed to determine benefits or the benefits payable for related services.**

Client signature: _____ Date: ☐☐-☐☐-☐☐