

PERSONAL INJURY FORM

TERMS AND CONDITION OF FILING WITH PERSONAL INJURY CARRIERS

I, \_\_\_\_\_, of \_\_\_\_\_, \_\_\_\_\_, hereby agree to the following terms below:

- ❖ If I have completed 6 visits and no payment has been received from my insurance, or my insurance has stopped paying. I will start making regular payments that have been mutually agreed upon.
- ❖ If this should become a settlement case. I will then make payment arrangements, as I understand Hands on Health does not consider a settlement case as an acceptable payment unless otherwise agreed upon.
- ❖ If my insurance company has paid its maximum allowable benefit, or denies any further payment, I allow Hands on Health to file claims with my health insurance carrier.
- ❖ I accept responsibility of any portion of my balance that remains unpaid (deductible, co-pay or co-insurance)
- ❖ I agree to abide by these terms and to maintain good communication with the Collection/Billing Department of Hands on Health until this account balance is paid in full.

\_\_\_\_\_  
Patient/ Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Driver's License Number

\_\_\_\_\_  
Approved By

\_\_\_\_\_  
Date

On behalf of Hands on Health (Ann Wilkinson P.T.M.S.)