**Notice of Insurance authorization & Assignment of Benefits to a Provider**

An assignment of benefits is an arrangement by which a patient requests that his or her health insurance benefit payments be made directly to a designated person or facility, such as a physician or other healthcare professional.

Please be advised that the patient’s signature or, in the case of a minor or mentally handicapped individual, the signature of a parent or legal guardian, provides for the assignment of benefits to Active Therapeutic Solutions authorizing this transfer of payment from the insured to the healthcare provider.

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Print the full name of the undersigned]

hereby authorize Active Therapeutic Solutions to apply for benefits on my behalf for services rendered to me or my dependent(s) and request that payment made by my insurance company be sent directly to Active Therapeutic Solutions. I understand that Active Therapeutic Solutions does not participate with my health insurance carrier and will therefore bill as an out of network provider.

I certify that I (or my dependent(s)) have active and valid insurance coverage and have supplied Active Therapeutic Solutions with up-to-date and correct insurance identification card(s) as well as all necessary information regarding the guarantor and the subscriber(s) eligible for insurance benefits. Failure to provide updates to any of the information supplied may result in denial of payment to Active Therapeutic Solutions.

I understand that it will be my responsibility to pay Active Therapeutic Solutions for those medical services rendered to me or my dependent(s), regardless of whether or not paid by insurance. I understand that if I receive a check from my insurance carrier it is my responsibility to immediately pay that amount to Active Therapeutic Solutions.

I understand that that it is my primary responsibility to pay for services rendered to me, and if my account is turned over to an attorney or agency for collection or taken to court, I agree to pay any collection fees, legal fees, court costs, and other expenses incurred as a result of said collection or court date. Further, I understand that there is a $30.00 fee for returned checks.

I understand that Active Therapeutic Solutions will report to commercial credit bureaus only when an account becomes delinquent. Accounts having no payments within 30 days of the initial debt notice are considered delinquent for payment purposes. After 90 days, all delinquent accounts are reported on the consumer credit report and reported to the IRS as income for the client. The debt will remain on the credit bureau report until it is paid in full.

I certify that the information I have reported with regard to my insurance coverage is correct and I hereby authorize Active Therapeutic Solutions to release any information relating to any claim for benefits, in order to process any claim for benefits and to secure the payment of benefits.

I authorize the use of this signature on all insurance submissions. Furthermore, I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

Signature of Client or Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_

Client (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_