



FINANCIAL POLICY & AGREEMENT for WORKERS' COMPENSATION CASES

I understand and agree that:

1. It is my own responsibility to understand my insurance coverage and benefits under the Workers' Compensation as it relates to the service I am about to receive.
2. Pillars Physical Therapy and Wellness Center will undertake my treatment on the basis of my doctor's prescription indicating the diagnosis, and on the authorization provided by the insurance company. Said authorization should indicate the number of visits with the physical therapy clinic which I am entitled to receive, and should include the start and end dates of the treatment.
3. Provided that I submitted my doctor's prescription and the authorization from the insurance company, and that I complied with the start and end dates of the treatment plan, I shall bear no financial liability of any sort with the clinic.
4. Pillars Physical Therapy and Wellness Center does not accept any attorney, third party, or personal injury liens.

I have read, understood and accepted the terms of this agreement. I am the patient, or the party authorized by the patient (as guardian or general agent), to execute this agreement.

Patient's Printed Name

Patient's Signature

Date

**Guardian's/General Agent's
Printed Name**

Guardian's/General Agent's Signature

Date