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 responsibilty 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.)