Financial Agreement of Non-Coverage

I, ____________________________, acknowledge I am seeking treatment from Momentum Physical Therapy. I understand Momentum Physical Therapy will submit medical claims to my health insurance(s). I am aware that any remaining balances or any denials determined by my insurance are my financial responsibility.

Furthermore, I acknowledge that if I fail to provide accurate and current insurance information, **all** denied claims will be my financial responsibility.

Name of Insurance(s):

1. Primary: __________________________________
2. Secondary: ________________________________
3. Tertiary: __________________________________

I have read and understand the above financial agreement and hereby authorize Momentum Physical Therapy to secure the payment for my treatment.

_______________________________ _______________________
Patient or Guarantor Signature Date

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(Relationship to Patient)