**Financial statement for A Better Way Physical Therapy LLC**

By signing below your consent for A Better Way Physical Therapy to bill your insurer.

I will bill your insurance. Should my claim be denied for any reason, you are responsible only for a co-pay (if applicable) and deductibles. I will not issue a bill if the claim is denied due to errors on my part or that of billing concerning coding or documentation.

Signing here I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge I am responsible for only my copay or deductible and I provide consent for A Better Way Physical Therapy LLC to bill my insurer.

Sign name DATE

CONFIRMATION

Signature DATE