HEAD TO TOE PHYSICAL THERAPY

SOUTH ORANGE REHABILITATION & WELLNESS

AUTHORIZATION FOR UNPAID BALANCES

I hereby certify that I am a patient at South Orange Chiropractic Center. **I understand that I am only paying a co-pay or co-insurance at the time of service.** I also understand that my insurance company, Horizon Blue Cross Blue Shield, will be sending checks to me that are for services rendered by South Orange Chiropractic Center. **I understand that while these checks are made out to me, or the primary insurance holder, they belong to South Orange Chiropractic Center for the services they have provided to me.** If I do not bring in the checks from my insurance company, or reimburse South Orange Chiropractic Center for the check amount, within fifteen (15) days of receiving the check, I authorize South Orange Chiropractic Center to charge my credit / debit card for the appropriate amount of the re-imbursement, taking into consideration all with-standing deductibles, co-payments, and policy provisions.

Furthermore, I understand that if my failure to make the above payments results in my file being sent to collections, I will pay an additional 33.33% of the outstanding balance as reimbursement to the doctors for legal fees. This is an addition to any court costs and constable fees that are allowed by the court.

I also understand that if I am inadvertently overcharged, I will receive a refund immediately.

Card Holders Name: _____

CC / Debit Card Number: _____ Exp. Date: _____

Patient's Name: _____ Date: _____

Patient's Signature: _____

Witness' Signature: _____

SOUTHORANGEREHAB.COM
177 VALLEY STREET
SOUTH ORANGE, NJ 07079
T-973-761-0077
F-973-761-0024