



**PARADISE VALLEY**  
F A M I L Y C A R E

**JOHN D. MARSHALL, M.D.**                      **DANIEL D. SMITH, D.C.**  
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**PATIENT PHYSICAL MEDICINE AGREEMENT**

\_\_\_\_\_ I understand that my health insurance may or may not cover the physical modalities/ physical medicine performed in the above mentioned office as per \_\_\_\_\_ benefits, and It’s definition of “medical necessity,” once the claim has been filed. I also understand that I may be responsible for a co-pay, co- insurance and/or deductible.

\_\_\_\_\_ I understand and agree that it is my responsibility to ensure payment for the non covered services or for those services that were deemed “not medically necessary” by \_\_\_\_\_.

**OR**

\_\_\_\_\_ I understand that you are billing my private health insurance as a courtesy in regards to a third party liability injury. I also understand that my private health insurance may or may not cover the physical modalities/physical medicine performed in the above mentioned office and that I am responsible for all non covered services and limitations due to my benefits and “medical necessity.”

\_\_\_\_\_ I understand that my private insurance \_\_\_\_\_ will not cover physical medicine performed in office and I choose to waive my right in going to a covered facility due to a third party liability claim. I understand that my Med-Pay coverage from my automobile insurance will be the primary insurance billed, and then payment for the remaining balance will be expected upon receipt of my third party claim.

\_\_\_\_\_ I understand that I am being treated on a lien basis (County Lien and/or Attorney Lien); that I am fully understand my choices of care; and payment for all services is expected upon receipt of my third party claim. I further understand I am responsible for all collection cost if I fail to pay for these services once the third party claim has been settled.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness