Pro-Activities, LLC
8254 Mayfield Rd Unit 7 Chesterland OH 44026 Phone: (440) 729-0405

INSURANCE AGREEMENT FORM

Patient: _____ Date: _____

I hereby acknowledge that Pro-Activities, LLC is not now or was at any time acting as an agent of the said insurance company or to you the patient. We pre-certify your insurance as a convenience and we strongly urge you to consult your policy booklet, as occasionally the information given to us over the phone is incorrect. We will not be responsible for incorrect information/authorization given to us by yourself or your insurance representative. The pre-certification has been explained to my satisfaction and I fully understand my responsibility to check with my policy book for the most up-to-date information before beginning treatment. **Therefore, it is your responsibility to be aware of your own plan and its conditions.**

You are responsible for any deductibles, co-pays or any other non-covered services per ***YOUR*** individual policy. If your policy or plan changes during the time of treatments, you must notify us **immediately**. **Failure to do so may result in a balance owed by you**.

You may receive an Explanation of Benefits (EOB) in the mail from your insurance company. **If** your insurance sends you a check as a payment for services, **please bring us the check AND the EOB**. Review the EOB closely, it will state the amount which Pro-Activities charges, receives and payment from the insurance company, adjusts, and if there is a remaining balance due from YOU directly.

Your Insurance Company Name:
Coverage/Benefits: Your secondary insurance, if applicable, has been contacted and the coverage is as follows:

Auto Insurance: For auto benefits, your insurance carrier does not tell us the remaining benefits. *It is your responsibility to find out this information.*
Workers Compensation (If applicable):

I, _____, *agree* to pay Pro-Activities for any and all services rendered to me including co-pays, deductibles, co-insurance and non-covered services.

I have read and understand the above information.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date