



Dr. Michael Troknya Dr. Kristin Rayball  
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Office Policy and Insurance

This agreement is between PHYSICAL SYNERGY and \_\_\_\_\_  
(patient name)

I \_\_\_\_\_(patient name), do hereby authorize and agree to pay for services rendered to me by DR. MICHAEL TROKNYA during my course of treatment as agreed upon. I also hereby authorize and agree to pay in full any outstanding balance due on my account if requested at the time of my release from care.

I instruct an insurance carrier that may be liable to pay my physician directly for any outstanding medical bills.

I understand that if I have a personal injury protection policy (PIP) that it is the contractual obligation of my insurer to pay any and all medical bills, which are the result of an automobile accident, unless my benefits have been exhausted. I instruct any insurance company that may be liable to pay to pay my doctor within 30 days of the date of receipt of my claims, as required by the Connecticut Department of Insurance, by way of issuance of a separate draft make payable to PHYSICAL SYNERGY.

In the event I so choose to have any attorney represent me in this case, I do hereby instruct said attorney to pay in full any outstanding monies due my physician at the time of settlement with any liability claim that may result form this case. My attorney shall not withhold any portion of the amount due to my physician under this agreement to offset attorney's fees. I also instruct my attorney to pay my doctor immediately upon settlement, by way of issuance of a separate draft made payable to PHYSICAL SYNERGY.

I understand and acknowledge that all charges incurred by me are my responsibility regardless of any settlement made by any insurance companies. I am instructing and agreeing to the above conditions as a safeguard to the physician's right to collect payment.

I understand that PHYSICAL SYNERGY has the right to expect good faith payments on my account and that full payment is being deferred only until such time as any insurance company makes payment on my account. If a settlement does not occur within a reasonable amount of time, I agree to make other arrangements to pay my account in full.

I understand that PHYSICAL SYNERGY does not render any services on the assumption that their charges will be paid by any insurance company. Patients who carry health insurance should remember that professional services are rendered and charged to the patient if not paid in full by the insurance company. This excludes patients with an accepted workers' compensation injury. Insured patients are expected to take care of their fees and/or patient portion as services are rendered. Even though an insurance claim is filed, you will receive a statement if your account has a balance due.

**Methods of payment**  
**(Accepted workers' compensation patients are excluded)**

- A. Payment at the time of service is expected unless prior arrangements are made in advance. Cash, checks and credit cards are accepted.
- B. If participating in the WellCare Program, which allows the patient to pay in advance for the recommended adjustments, and thereby receive subsequent savings, or other cash payment agreement, the patient's insurance company will not be billed. However, if the patient suffers an injury or illness, which merits injury/illness care, the patient's insurance may be utilized.

\_\_\_\_\_  
Patients Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Parent or Guardian Signature

\_\_\_\_\_  
Date

**Acknowledgement and Agreement of Receipt**

As the insurance adjuster or attorney on this claim, I acknowledge that I have received notice of the patient's agreement above and will abide as agreed upon and instructed from \_\_\_\_\_(patient's name).

\_\_\_\_\_  
Adjuster or Attorney Signature

\_\_\_\_\_  
Date