Patient Name: _____ Date: _____

Practice Representative/Witness: _____

_____

Agreement to Pay in Full if Insurance Does Not

Note: If your insurance company doesn't pay for the services listed below, you will be financially responsible for the total amount due. It is our experience that many insurances will not cover these services or deny once we bill them.

Services your insurance may not pay for	Reason your insurance may not pay	Estimated Cost
Physical Therapy Services	Your insurance coverage may not cover your physical therapy treatment. Insurance can say that services were not medically necessary or that authorization was not received, or that you did not have active coverage, or they do not cover a certain procedure for the services rendered. You can also max out your benefits.	You will be billed the allowable for your Insurance coverage per the contracted amount.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the services listed above.

Signing below means that you have read this notice, **want to receive this service**, and **agree to be financially responsible** for the full cost of the service in the event insurance does not pay for it.

Signature:	Date:

OR

Signing below means you have read this notice and are declining this service.

Signature:	Date:

Litigation/Liability Accounts: We require a fifty percent (50%) payment at the end of each appointment unless prior payment arrangements have been made with the Medical Billing Manager.
Worker's Comp Accounts: Employer verification of a claim is not a guarantee of payment from the employer or their insurance carrier. If a claim is denied, you will be responsible for payment. We ask that patients with workers comp provide us with a secondary insurance such as health insurance in case the claim is denied. Some health insurance carriers require pre-authorization making it necessary that we obtain the authorization at the time of service, as most will not authorize the services retroactive to the treatments.
Self-Pay Accounts: Patients not covered by insurance are eligible for a discount if they pay for their visit at the time of service. If accounts are not paid at time of service, the discount does not apply.
I understand and agree that I am ultimately responsible for the charges incurred for my treatment.

I certify that I have read both pages of this document and agree to the terms and conditions herein.

PRINT FULL LEGAL NAME:_____ **DATE**:_____

SIGNATURE:_____ WITNESS:_____

Assignment of Benefits and Release

I authorize the assignment of benefits for my insurance carrier to pay . directly for my treatment. I agree that I am financially responsible for non-covered services including some medical supplies, collection fees, interest, and cancellation and no-call/no-show charges. I also understand that I am responsible for any co-payment and/or deductible and coinsurance associated with my insurance policy.
I authorize the release of any and all medical information necessary to determine liability for payment and to obtain reimbursement including medical records to any person or corporation that is or may be liable for payment and to obtain reimbursement including medical records to any person or corporation that is or may be liable for all or any portion of the charges incurred. I authorize any holder of medical or other information about me that it be released to the Social Security Administration or its intermediary carriers any information needed for this or related Medicare claims.

PLEASE SIGN:_____ **DATE**:_____
Patient Signature (Parent/Guardian if patient is minor)

WITNESS:_____

HIPAA NOTIFICATION: I have been informed of the HIPPA Notification that is posted in the front lobby. I have been offered my own personal copy of the HIPPA Policy.

SIGNATURE:_____ **DATE**_____

WITNESS:_____