Patient Benefits Agreement

PLEASE READ CAREFULLY!

Patient responsibility for out of pocket insurance costs:

Please be advised that if your insurance benefits indicate that you have a deductible, co-insurance (percentage), or co-pay for Physical Therapy services we are obligated by the insurer to collect these fees. In addition, it is our office policy to collect these fees at the time of each office visit.

Allow us to clear up some common terminology:

Deductible: A lump sum that the insurer states that the patient is responsible for covering BEFORE the insurance company begins paying for services.

Co-insurance: A percentage amount that the patient is responsible for of the total amount allowed, per visit. (Ex: Insurer allows $100 for office visit; @ 20% co-insurance, patient pays $20, insurer pays $80.)

Co-pay: Specified amount set forth by insurance company for which the patient is responsible per visit.

In order to minimize large bills at the conclusion of treatment, we will collect a reasonable estimate of your expected out of pocket cost per visit in terms of deductibles and co-insurances until the maximum out of pocket costs are met. All balances will need to be settled at the conclusion of treatment once all claims have been processed.

For deductibles, we will collect $100.00 for the initial evaluation and treatment session, and $75.00 for subsequent treatment sessions. For co-insurances, we will collect the percentage as a dollar amount, i.e. 20% co-insurance, we will collect $20.00/visit.

We accept cash, check, and Visa, Mastercard or Discover. Please inform us if you have a Health Savings Account or Health Fund that will be covering your treatment-related expenses.
Thank you for your cooperation.

Benefits Summary:

Deductible_____ Co-insurance _____ Copay_____
Out of Pocket Maximum _____ Remaining _____ Visit limitation_____
Referral required? _____ (Please be advised you are responsible for obtaining referrals from your primary doctor's office.)
Other _____

*****Finally, it is the patient's responsibility to know the benefits and limitations of his or her personal insurance policy. We verify benefits as a courtesy to you, but you should contact your insurance carrier as soon as possible if you have any questions regarding your benefits for outpatient physical therapy services. By signing below, you agree that you understand your benefits, and are aware that you are fully responsible for payment of services once benefits are exhausted.*****

Date: _____ Date: _____

_____ _____
Patient Signature Business Office