



Patient Name: _____

Patient Financial Responsibility

The Physical Therapy (PT) service you have chosen implies a financial responsibility on your part. This financial responsibility obligates you to ensure payment in full for our services. As a courtesy, we will attempt to verify your primary insurance carrier on your behalf. If our office does participate with your insurance, we will file a claim on your behalf. However, once the insurance company is billed we allow 60 days for the balance to be paid by your insurance carrier. If the insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If our office does not participate with or except assignment from your health insurance, payment in full will be due at the time of service.

Additionally, our office will file a claim on your behalf with any secondary insurance carrier you may have. However, as stated above, if your secondary insurance carrier does not remit payment within 60 days, the balance will be due from you in full.

Claim denials due to no referral or authorization are the patient's responsibility. Office staff will assist you in referral/pre-certification procedures, but final responsibility lies with the patient to comply with their specific insurance's requirements. All referrals, prescription(s) for therapy, and insurance cards must be presented to our business office before seeing the therapist.

Additionally, you are responsible for payment of any deductible, co-payment/co-insurance as determined by the contract with your insurance carrier. We expect these payments in full on the day the service is rendered. Often times, insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elect to continue Physical Therapy past your insurance's approved visits or time frame, you will be responsible for your account balance in full.

If your account must be forwarded to a collection service because of non-payment, you will be responsible for all collection fees charged.



I have read the above policy, and agree to these terms, regarding my financial responsibility to STRAIT Physical Therapy for rendering rehabilitation services and certify that the information is true and accurate. I authorize my insurer to pay STRAIT Physical Therapy the full amount for services incurred by the primary insured (self) or other covered patient named above.

Your benefits (as verified by STRAIT Physical Therapy) are below:

Co-Payment: _____

Deductible: _____ and then the insurance will reimburse at
_____ % up to _____ maximum lifetime benefit.



Patient Signature: _____

Guarantor Signature: _____

(If guarantor is not the patient)

Date: _____