FYZICAL Therapy & Balance Centers

Financial Policy, Assignment & Treatment Consent

~For our patients, we are enrolled in numerous insurance programs and managed care plans where we bill the carrier of your charges.

~While we are pleased to offer this service to you, it is impossible to keep track of all the individual requirements for each plan. Even with the same company, the plans differ depending upon what type of contract your employer has chosen for the employees.

~We will call your insurance company when you first come in for therapy to see what your co-payment amount is and also to see if your deductible has been met. ***We do collect your co-pays and deductibles at time of service. *REMINDER:*** *Your insurance company is* ***your*** *payer of services so you should call them to check your benefits before you come to therapy. What they do not pay could become your balance especially if prior authorization was to be obtained before you had the service but was not obtained.* ***We cannot be responsible for your requirements within your policy.*** *We are often given wrong benefits when we call the insurance companies. If we both call, we have a better chance of taking care of problems ahead of time.*

- ***Financial Agreement/Treatment Consent/Assignment:***

The undersigned agrees, as patient or agent of patient, that the patient is accepting financial responsibility for services rendered and is obligated to pay their balances due at time of service and all balances that may be denied by your insurance company after you file your claim.

I authorize the staff of FYZICAL Therapy Balance to provide me with treatment as deemed necessary by my Dr. or Therapist. I hereby authorize PTRC to release information to my insurance company and to receive direct payment from them for my services. I also understand that this authorization does not release me from my personal responsibility for payment of all charges.

Please sign below consenting to the above paragraphs

Name:_____ SS#:_____

First Middle Last ###-##-####

Signature:_____ Date:_____

Sign after printing MM/DD/YYYY

Medicare patients receiving home health services of any kind are NOT eligible for outpatient physical therapy.

Are you currently receiving home health? ☐ Yes ☐ No

Please initial _____

Initial after printing