Lifestyle Physical Therapy, Inc.

Financial Liability Disclosure Policy

I authorize the assignment of benefits for my insurance to pay Lifestyle Physical Therapy, Inc. directly. I understand that I am ultimately responsible for the charges incurred by Lifestyle Physical Therapy, Inc. I understand that Lifestyle Physical Therapy will bill my insurance company, but it is my responsibility to follow up on claims submitted if payment is not received in a reasonable amount of time.

I authorize the release of all medical information (including medical records) necessary to determine liability for payment and obtain reimbursement to any person or corporation, which is or may be liable for all or any portion of charges. I am responsible to notify Lifestyle Physical Therapy if there are any changes to my insurance coverage or contact information. It is my responsibility to maintain a current prescription for physical therapy.

I understand that while Lifestyle has made every effort to verify my insurance benefits, I was advised to call my insurance as well. I also understand that payment will be due at each visit upon arrival.

Co Payment Policy

I understand that I will be responsible for a co-pay of $_____ per visit.

Deductible Policy

I understand that I have a yearly deductible of $_____. If this deductible has not been satisfied I will be responsible to pay $_____ for the initial visit and $_____ for subsequent visits until my deductible has been met. Once my deductible has been met, I will be responsible to pay $_____ per visit.

Coinsurance and Co Payment Policy

I understand that I am responsible for a _____% co-insurance plus a $_____ co pay. I understand that I will pay $_____for the initial visit and $_____ for subsequent visits.

I understand that the above amounts are approximations and may vary depending on how my insurance processes my claims.

Patient / Guardian Signature _____ Date_____

Facility Witness Signature _____ Date_____