Lifestyle Physical Therapy, Inc.

Financial Liability Disclosure Policy-Medicare

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.

Home Health: To protect you from unexpected financial liability in these cases, and to comply with Medicare Conditions of Participation, it is important that all providers and suppliers serving a Medicare patient notify the beneficiary of the possibility that they will be responsible for payment.

In certain circumstances, I may receive services from a home health agency (HHA) and the primary HHA is unaware of outside services being provided during the episode of care; I may be liable for payment for these services.

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.

I understand I have a yearly deductible of $185.00. My secondary insurance may cover my deductible. Once my deductible has been met, I will be responsible for a 20% coinsurance which is **approximately** $30 per visit. My secondary insurance may cover 100% or a portion of my co-insurance.

Please be aware of your yearly Medicare benefit cap of $2,040.00

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_____

My insurance benefits were explained to me on_____ and on my initial visit_____

Updated 02/06/19