Lifestyle Physical Therapy, Inc.

Financial Liability Disclosure Policy

I authorize the assignment of benefits for my insurance to pay Lifestyle Physical Therapy, Inc. directly. 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, and that I am ultimately responsible for the charges incurred by Lifestyle Physical Therapy, Inc. 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. It is my responsibility to maintain a current prescription for physical therapy and to notify Lifestyle Physical Therapy if there are any changes to my insurance coverage or contact information. I understand that while Lifestyle has made every effort to verify my insurance benefits, I was advised to call my insurance as well. 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. I am allowed_____ visits per year.

Deductible Policy

If my deductible of $_____has not been satisfied I will be responsible to pay $_____ for the initial visit and $_____ for each subsequent visit until my deductible has been met.

Once my deductible has been met, I will be responsible to pay $_____ for my initial visit and $_____ for each subsequent visit. I am allowed _____ visits per year.

Coinsurance and Co Payment Policy

I understand that I have a _____% co-insurance plus a $_____ co pay policy.

If my deductible of $_____has not been satisfied I will be responsible to pay $_____ for the initial visit and $_____ for all subsequent visits until my deductible has been met.

Once my deductible has been met, I will be responsible to pay $_____ for my initial visit and $_____ for each subsequent visit. I am allowed _____ visits per year.

I understand that the above amounts are approximations and may vary depending on how my insurance processes my claims and that I am ultimately responsible for the charges incurred by Lifestyle Physical Therapy, Inc.

- I acknowledge that I have received a copy and/or email of this agreement OR
- I have declined a copy and/or email of this agreement: Patient initials_____

Patient Signature _____ Date _____

Facility Witness_____ Date_____

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

Updated 02/06/19