REFORM PHYSICAL THERAPY
Don't neglect your health, reform it

Patient Name: _____ DOB: _____

Guarantor Name *(if not self)*: _____ DOB: _____

We have made contact with your insurance carrier(s) and, at this time, they have indicated the following:

Primary Insurance: _____

Deductible: _____ Amount Applied to Date: _____

Maximum Billable Amount: _____ Amount Applied to Date: _____

Co Pay: _____ Coinsurance: _____

Visits Allowed: _____ Used to Date: _____

If you have a deductible, we ask that you pay $125.00 per Initial Evaluation and $90.00 per Standard Visit, as an estimate of how much the visit will cost.

Secondary Insurance (*if applicable*): _____

Deductible: _____ Amount Applied to Date: _____

Maximum Billable Amount: _____ Amount Applied to Date: _____

Co Pay: _____ Coinsurance: _____

Visits Allowed: _____ Used to Date: _____

If you have a secondary insurance, your financial responsibility will vary based on the coverage of your primary insurance.

- You agree to be held financially responsible for any and all charges regardless of benefit or applicable insurance payments, resolution of a legal action or lawsuit, or third-party interest.
- Interest in the amount of 10% per month may be added to your bill for any and all claims that are not paid within sixty (60) days of the statement or invoice date. You agree to be personally responsible for such interest unless the responsible Payor is required to pay such interest under state, federal, or other applicable laws.
- If you have a copay, please understand that payments are expected in full at the time of service.
- If you have a deductible, please understand that you are responsible for 100% of the charges **until** your deductible is met**. We ask that those with a deductible pay $90.00 per standard visit and $125.00 per evaluation, as an estimate of how much the visit will cost.** Please be aware, the cost may vary based on specific charges the Physical Therapist bills on any given day.
- Any account without payment in excess of sixty (60) days will be forwarded to a collection agency. Should collection proceedings or other legal actions become necessary, please understand that we are not required to obtain your permission before disclosing protected health information to a court of law or collection agency. Should collection proceedings prove necessary, you will be responsible for paying any collection costs, court costs, or filing fees incurred by the practice.

Please verify this information with your insurance carrier, as we are not responsible for any incorrect information your carrier has relayed to us.

By signing below, I verify that I have read and agree with the above.

Signature: _____ Date: _____