Statement of Financial Responsibility

Patient Name: ______________________________ **Date:** __________ **Acct #:** ____________________

Reger Physical Therapy appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible /coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, regardless of the reason for the denial(s), or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. For your convenience, we accept cash, checks, and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement. Payments can be made at the center, mailed to the address on your statement, or by calling our office at 677-9112.

If you are unable to pay your bill for whatever reason, please contact our office at 677-9112 and we will work with you to resolve the situation. However, once we have exhausted our internal efforts to obtain payment for service, we will, as a final resort, refer accounts to an outside collection agency. These agencies report delinquent accounts to credit reporting services. You will also be charged for the fees that we incur trying to collect on your account, including attorney fees and costs, if necessary.

I have read the above policy regarding my financial responsibility to Reger Physical Therapy for providing rehabilitative services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Reger Physical Therapy. I agree to pay Reger Physical Therapy the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Signature: ________________________(relationship to patient: self - guardian - other: __________) **Date:** __________

Authorization to Release Information

I authorize Reger Physical Therapy to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

Signature: ______________________(relationship to patient: self - guardian - other: ___________) **Date:** __________

Revised 12/13