Statement of Financial Responsibility

Please read through clinic policies and initial:

If proof of insurance/eligibility cannot be provided, payment will be due in full at time of service. _____ ←

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 provider. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurance provider. If your insurance provider 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. _____ ←

Insurance is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance provider regarding deductibles, co-pays, covered charges, secondary insurance, "usual and customary" charges, etc. _____←

Balances on your account must be paid in full unless a payment arrangement has been made. Payment plans can be arranged with the front office or billing department; all balances must be paid within 90 days. _____←

Once all attempts to collect on delinquent accounts have been made, they are subject to collections processes which may include the account being transferred to Cornerstone Credit Services. At that point, past due balances must be settled through CCS. _____←

If after a review of the information stated above you have any questions about your health insurance coverage regarding physical therapy, **we ask that you please contact your insurance provider to discuss the details of your plan(s).** Our office strives to estimate your insurance benefits as accurately as possible. However, your insurance policy is a contract between you, your employer (if applicable) and the Insurance Company providing your benefits. The eligibility and benefits stated above are a complete record of the information that our office received while verifying your account(s). As stated by the provider, "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

By signing below, you acknowledge that the benefits stated above have been explained to you and, to your knowledge, are accurate and consistent with your health care insurance plan(s).

Signature:_____ (Relationship to patient: Self/Guardian) 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) Date:_____