Patient Waiver

Name: _____ Date_____

The following information is provided to enhance your understanding of your rights and responsibilities as our patient.

Insurance Information

• Please be aware of your insurance benefits and physical therapy coverage. Physical Therapy is a specialty service and generally differs from standard medical benefits. It is your responsibility to verify your present benefits (deductible, co-insurance, copay, etc.) through your insurance carrier.

• Your insurance coverage is an arrangement between you and your carrier. If you have questions regarding your insurance benefits, please call your insurance company's customer or member service department (phone number is usually located on the back of your insurance card).

• Upon treatment, you will be responsible for any amount not covered by your insurer (unless a financial agreement was made between you and the manager), including, but not limited to deductibles, co-insurance and co-payments, as stated in your benefits package. In addition, all co-payments and co-insurances will be collected at the time services are rendered.

• If your insurance carrier denies any part of your claim, or if you or your physician would elect to continue therapy past the approved period of time or authorized visits, you would be responsible for any charges incurred beyond that point of time. Please see form for service agreement fee. If this were to happen, you would be eligible for a discount for self-payment.

• Potential Physical Therapy must receive payment within 30 days after your first billing statement. All accounts beyond 30 days are subject to collection agency fees and or small claim court costs.

¨ I have read the above statement. It is my understanding that I am financially responsible to Potential Physical Therapy for providing therapy services to me, or the above patient.

(Pt. Initials) _____

¨ I authorize my insurer to pay any benefits directly to Potential Physical Therapy and I AGREE TO PAY Potential Physical Therapy THE FULL AMOUNT OF ALL BILLS INCURRED by myself, or the above-named patient. If applicable, I will pay any amount due after payment has been made to Potential by my insurance carrier (co-insurance/deductible etc.)

(Pt. Initials) _____