Patient Financial Agreement

Bodywise Physical Therapy *i*s devoted to serving our patients with professionalism and courtesy, we count on our patients to do the same.

Patient payments of CoPays/Deductibles are required at the time of arrival.
Please notify us 24 hours in advance of your appointment to avoid our **$75. Cancellation Fee.**
Our **No Show Fee is $75.**

We accept most major Insurance Companies.
Please provide current/accurate information for your Primary and Secondary/Supplemental Insurance Benefits.
Prior to your first appointment, please provide Referrals from other Medical Providers and Identification/Insurance Cards.
*All Medicare patients require a Referral prior to your first appointment, to avoid denial of claims/coverages.

Bodywise Physical Therapy will submit all Primary and Secondary/Supplemental Claims.
As a courtesy, we will contact your insurance to verify/review physical therapy benefits/coverages.
We will estimate Patient Responsibility of payment and Insurance Responsibility of payment.
The amount collected at each visit is determined by combining CoPay, Coinsurance, Deductible and Out of Pocket.

Estimated Insurance Benefits: (*Bodywise Physical Therapy* will fill in at your first appointment)
Individual Deductible $ _____ Amt Met $ _____ Amt Remaining $ _____
Family Deductible $ _____Amt Met $ _____Amt Remaining $ _____
Coinsurance _____/ _____ % Visits Allowed _____ Visits Used _____
Individual Out of Pocket $ _____Amt Met $ _____ Amt Remaining $ _____
Family Out of Pocket $ _____ Amt Met $ _____ Amt Remaining $ _____
CoPay/Amt Per Visit $ _____
Patient will be paying $ _____ collected each visit, to be applied toward:
Deductible ____ Coinsurance ____ CoPay ____ Out of Pocket _____
*As the physical therapy claims process, any remaining balance will be patient responsibility. Patient is liable for any costs not covered under Insurance Plan.

I understand and agree if I fail to make payments for which I am responsible in a timely manner, I will be responsible for all cost of collecting monies owed/collection fees, including court costs/attorney fees, plus interest thereon at 18% per annum on all such amounts outstanding. *Bodywise Physical Therapy* has a $25. Service Charge on all returned checks and additional charges for the cost of the collection.

I have read and understand the above Patient Financial Agreement:

Please sign here: _____

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