BLUE BELL PHYSICAL THERAPY
PATIENT FINANCIAL WAIVER

Patient name____

Thank you for choosing Blue Bell Physical Therapy for your rehabilitation needs. You can expect quality, hands on, personalized care that will generate results. In exchange, we expect that, after undergoing a full explanation, you understand your financial responsibility. This responsibility obligates you to ensure payment in full of our fees. We will verify your insurance coverage and bill your insurance carrier on your behalf. By doing so, we will meet our obligation to ensure that your insurance carrier has all the necessary information to make payments on your behalf, however, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as stated by your contract with your insurance carrier. We expect these payments when services are rendered. Please be aware that some insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your carrier. **The cost for an initial evaluation is $130**. If your insurance carrier denies any part of your claim, or, if after consulting with your physician, the need exists to continue therapy beyond the approved coverage by your insurance carrier, **the cost is $75 for each visit**.

Medicare covers Outpatient Physical Therapy, Occupational Therapy and Speech-Language Pathology services at 80% of the Medicare Fee Schedule rate after a ________ annual deductible for 2015. Your secondary insurance may cover all or part of these required fees. Medicare does not disclose information regarding coverage eligibility for there fees to providers.

If you have a plan other than Medicare, your out-of-pocket expense is:___________________________

Your Insurance should pay:____

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

PATIENT SIGNATURE:_____________________________________DATE:_____________

GUARANTOR
SIGNATURE:____DATE:_____________
(if guarantor is not the patient)