Preferred Physical Therapy

Financial Policy/Agreement

Please call your insurance carrier so that you can better understand your benefits. Although our office does verify coverage, online services only provide limited information. While we try to obtain accurate insurance benefits we are occasionally given incorrect information. If this occurs, you are responsible for any difference in what was quoted by your insurance company and what was actually paid.

If your insurance company requires you to have a referral or authorization for physical therapy, please verify with our front desk that a current referral or authorization is on file.

Our office will put forth as much effort as possible to help obtain these documents, however, the patient is ultimately responsible for any resulting costs that may be associated with your visits.

It is your responsibility to know which insurance is your primary carrier and which is your secondary. We rely on the information that you provide. Your signature below further verifies you have not joined an HMO or other entity in which your Medicare or other insurance benefits have been relinquished.

If your visit today is due to an automobile or personal injury accident, please notify the front desk. If you have an Attorney representing you for the accident, please notify the front desk. It is your responsibility to give us correct information at the time of the visit.

THE PATIENT IS HELD ACCOUNTABLE FOR UNDERSTANDING THEIR INSURANCE BENEFITS, VERIFYING NECESSARY REFERRALS/AUTHORIZATIONS ARE ON FILE AND PAYING SUBSEQUENT OUT OF POCKET EXPENSES.

Did you contact your insurance company to verify your benefits and out of pocket costs? ◯ Yes ◯ No _____
Patient Initial Here

We have verified your benefits and they have informed us that you have the following responsibility:

DEDUCTIBLE AMOUNT:	BALANCE REMAINING:
You are fully responsible for the charges each visit until your deductible in the amount listed above is met. After your deductible is met, you may be responsible for a co-pay or co-insurance depending on your specific plan.	

CO-PAY:	CO-INSURANCE:
(This is the fixed amount you will pay each visit after your deductible is met.)	(This is a percentage you will pay each visit after your deductible is met. This amount can change depending on your treatments.)
Other:	

Consent for Care and Treatment

I, the undersigned, do hereby consent to such treatment by personnel at Preferred Physical Therapy as may be dictated by prudent medical practice for my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Name of Patient (Print): _____

Patient/Guardian Signature:_____Date:_____

OFFICE 623.486.3333 FAX 623.486.3355 WEB preferredptaz.com
ADDRESS 18301 N. 79th Ave. B122 Glendale, Arizona 85308