Jeff Nicholl Physical Therapy & Sports Rehabilitation, Inc

Please read through the following information and initial to signify your understanding.

PRIVATE INSURANCE

We are currently collecting co-payments, co-insurance and deductibles in this office. We accept Visa, MasterCard, Discover, cash or check. We only accept PPO policies. **If your insurance is a calendar year plan**, you may have to meet your deductible for this calendar year. As you may or may not know, your insurance benefits will vary depending on the type of plan you choose to have with your insurance company. **As a courtesy,** we will call to find out your insurance benefits for physical therapy. However, many times we are given incorrect information. With this being said, **please call your insurance company to verify any and all benefit information that applies to you.** When calling, please ask for your **physical therapy** benefits; most times these benefits will vary from any Doctor's office visit.

If your insurance company states that your physical therapy benefits are **subject to an annual deductible**, this amount will need to be met before any co-payment or co-insurance benefit can be applied. Please do not confuse "**co-payment**" with "**co-insurance**", these are different. A co-payment is a fixed rate that you are responsible for at each visit. A "co-insurance" is what your insurance company deems customary and reasonable for the services rendered. This amount is based off of each visit and will not be determined until your Explanation of Benefits come out. Please understand that this amount, again, is an **estimate**. This means that you may be responsible for more or less. If you are responsible for more, the remaining balance will be billed to you; if you are responsible for less, you will be sent a reimbursement at the conclusion of your therapy. If your insurance company requires you to have an authorization **prior to the start** of physical therapy, it is your responsibility to know so. If your insurance company does require you to have a prior-authorization, and you **do not let us know**, you will be held responsible for any and all amounts denied by your insurance company. _____

WORKERS COMPENSATION, THIRD PARTY AND LIENS

If your therapy is following an **automobile accident**, please provide us with your attorney's contact information, if any. Also, please understand **we do not accept Third Party Billing or Liens in this office**. If your therapy is following a **work-related injury**, it is your responsibility to be sure we have all necessary paperwork **prior to the start** of physical therapy. If you have any questions regarding the paperwork required please contact your claims adjuster. Also, please provide us with your adjuster's name and contact information should we have any questions. _____

CANCELLATION AND NO-SHOW POLICY

If you are to cancel any appointment **within 24 hours notice**, a cancellation fee of $35 will be applied. If you fail to show up to a scheduled appointment without notification to our office, a no-show fee of $50 will be applied. Please understand this amount is solely your responsibility and will not be billed to your insurance company. These amounts will be due and payable at the time of your next visit. _____

I hereby give lifetime authorization for payment or insurance benefits to be made directly to Jeff Nicholl Physical Therapy & Sports Rehabilitation for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement is as valid as the original. I authorize that my signature on this form constitutes assignment of benefits to this healthcare provider.

Signed: _____ Date: _____