



PHYSICAL THERAPY

FINANCIAL POLICIES Patient Responsibility Agreement

Please INITIAL **one** of the following options:

I agree to pay:

____ co-pays at each visit.

____ co-pays in advance at the beginning of each week.

____ balance due in full upon receipt of each monthly statement.

Note: If you have health insurance; responsibility is not transferred to the patient until after an explanation of benefits is received from your carrier per each date of service. The patient responsibility will change as your insurance company processes each date of service.

____ set up a monthly payment arrangement (requires speaking with the billing department).

Agreement: \$_____ per month beginning _____ until patient responsibility is paid in full. ****If your balance exceeds _____ your monthly payment will need to increase to what is acceptable to MRPT.**

Authorized by: _____

I acknowledge verification of insurance benefit is done as a courtesy and is not a guarantee of payment, coverage or benefits stated by your insurance.

Note: If you have health insurance, we will submit it for you, provided current information is provided at the time of service.

Patient's Name – please print

Acct#

Patient's Signature: (Parent, if a minor)

Date