Physical Therapy Partners, Inc.
11085 Little Patuxent Parkway, Suite 207, Columbia, MD 21044
410.884.4111

FINANCIAL RESPONSIBILITY FORM

Your signature on this form indicates acceptance of the following statements:

Patient / Guarantor responsibility:

☑ Payment for all professional services rendered is the responsibility of the patient, parent, or guardian. Most insurance plans allow physical therapy only for rehabilitative treatment that works toward functional goals and is deemed medically necessary. When the patient has insurance that is reasonably expected to contribute toward payment for services, Physical Therapy Partners, Inc. will assist in the preparation and submission of insurance claims. **However, the patient is responsible for all fees regardless of insurance coverage.** Payment for all services, or the expected patient responsibility, is due when services are rendered. Payment of coinsurance and deductible is done based on reasonable estimate. If additional funds are required after the insurance claim has been processed, any balance will be billed to the patient. If the insurance company fails to process claims within 45 days from the date of service, the balance due may be collected from the patient. If insurance issues arise, it is the responsibility of the patient to contact the insurance company, group plan administrator, or employer representative for resolution. A patient's insurance policy is a contract between the patient and the insurance carrier. Physical Therapy Partners, Inc. is not a party to that contract and cannot act as mediator with the carrier or employer. Accounts with balances open more than 90 days may be charged interest on the unpaid balance at a rate of 5% per 30 day billing period. If it is necessary to refer the account to our collection attorneys, the patient agrees to pay the cost of collection including attorney's fees of 25%.

As required by insurance mandates, it is the responsibility of the patient to obtain any necessary authorization for medical treatments. If a referral is required for treatment, it is the responsibility of the patient to obtain the referral and present it at the time of treatment. In the event that the patient is treated without proper referral or authorization as required by the insurance carrier, the patient assumes responsibility for payment of all fees at the time of service.

Assignment of Insurance Benefits and Financial Responsibility Guarantee:

☑ I hereby assign any and all insurance benefits due and payable to me/us by my insurance policy for services rendered to Physical Therapy Partners, Inc. I further understand and agree that this assignment is non-revocable. I authorize Physical Therapy Partners, Inc. to release to my insurance carrier the paperwork necessary for processing payments related to physical therapy claims. I authorize any holder of my personal medical information to release to **Physical Therapy Partners, Inc.** any required information needed to determine insurance benefits. If required by my insurance carrier, I agree to provide all pertinent information necessary for completion of my treatment plan(s) and for the issuance of timely payments.

I understand that I personally guarantee to be financially responsible to pay Physical Therapy Partners, Inc. for any and all charges not covered by this assignment. All co-pays must be paid at the time of service in accordance with the contracted insurance carrier agreements. If my insurance carrier sends me payment for services incurred in this office, I understand that I am required to deliver the full payment to Physical Therapy Partners, Inc. immediately upon receipt.

Payments may be made by cash, check, or credit card (Visa, Mastercard, Discover).

I have read this document and I execute it with full knowledge, understanding, and acceptance of its contents:

_____ _____

Patient / Authorized Signature Date Signed

_____ _____

Witness Signature Date Signed