Patient Self-Pay Program

Complete only if you are not requesting insurance filing

Patient Name: _____ Date: _____ Med Rec #/Account# _____
(internal use only)

You have requested that your or your dependent's physical therapy visits be coded as "self-pay" services. By signing this form, you are acknowledging that you understand that the Provider will not be billing any insurance carrier for services provided, and that you are subject to the self-pay policies and guidelines of the Provider as listed below.

Note: The Self-Pay Program is not available to patients covered by Medicare.

Please be aware that:

- Self-pay services must be paid in full on the date of service.
- If you have health insurance that you are electing not to bill for services, you will likely not be reimbursed by your carrier nor be able to apply these payments toward your deductible.
- The Provider will not submit billing to your insurance carrier for previously completed self-pay visits if you choose to revoke your self-pay status at a later date.

Please check the appropriate box below.

☐ Patient does not have health insurance coverage.

☐ I am covered by a contracted insurance company, but I do not wish the Provider to submit a claim to my carrier. Instead, I elect to pay for all services out of pocket.

☐ Therapist/Facility does not participate in my health insurance plan.

☐ Service is not covered by my health insurance company.

☐ Non-covered Service: Type of Service:_____ Est. Cost per Visit:_____

Estimated Cost Per Visit:

Single Session - Evaluation is $195 / Follow up is $165
Single Telehealth Session - $80

-OR-

Silver Package - Up to FOUR 45 minute sessions in 1 month - $595
Gold Package - Up to EIGHT 45 minute sessions in 1 month - $1095
Unlimited Package - Up to ONE session per business day for 1 month - $2000

By signing below, I attest that I meet the requirements to participate in the Patient Self Pay program. The contents of this form have been explained to me, and I have voluntarily signed this agreement before receiving the described services. I have been told what the estimated costs will be. I agree to pay for the services in full or within the guidelines of a formally established payment plan between myself and the Provider.

_____ _____
Patient/Guardian Date

_____ _____
Printed Name of Responsible Party Relationship to Patient