Patient Self-Pay Program complete only if you are not requesting insurance filing

Patient Name:	Date:	Med Rec #/Account#
		(internal use only)
you are acknowledging that you understan	nd that the Provider will no	t be billing any insurance carrier for services provided, an
Note: The Self-Pay Program is not available	de that your or your dependent's physical therapy visits be coded as "self-pay" services. By signing this form, digning that you understand that the Provider will not be billing any insurance carrier for services provided, and ct to the self-pay policies and guidelines of the Provider as listed below. / Program is not available to patients covered by Medicare. hat: envices must be paid in full on the date of service. health insurance that you are electing not to bill for services, you will likely not be reimbursed by your carrie to apply these payments toward your deductible. ger will not submit billing to your insurance carrier for previously completed self-pay visits if you choose to ur self-pay status at a later date. appropriate box below. s not have health insurance coverage. d by a contracted insurance company, but I do not wish the Provider to submit a claim to my carrier. ect to pay for all services out of pocket. acility does not participate in my health insurance plan. of covered by my health insurance company. ed Service: Type of Service: Est. Cost per Visit: er Visit: ession - Evaluation is \$150 / Follow up is \$100 ckage - Up to FOUR 45 minute sessions in 1 month - \$350 kage - Up to EIGHT 45 minute sessions in 1 month - \$350 l Package - Up to ONE session per business day for 1 month - \$1,500 I attest that I meet the requirements to participate in the Patient Self Pay program. The contents of this form teed to me, and I have voluntarily signed this agreement before receiving the described services. I have been mated costs will be. I agree to pay for the services in full or within the guidelines of a formally established ween myself and the Provider.	
Please be aware that:		
 If you have health insurance that you nor be able to apply these paymen The Provider will not submit billing 	ou are electing not to bill ts toward your deductible to your insurance carrier).
Please check the appropriate box below.		
\square Patient does not have health insurar	nce coverage.	
	• •	t wish the Provider to submit a claim to my carrier.
☐ Therapist/Facility does not participate	te in my health insurance	plan.
\square Service is not covered by my health	insurance company.	
☐ Non-covered Service: Type of Ser	dent's physical therapy visits be coded as "self-pay" services. By signing this form, that the Provider will not be billing any insurance carrier for services provided, and indiguidelines of the Provider as listed below. To patients covered by Medicare. On the date of service. To are electing not to bill for services, you will likely not be reimbursed by your carrier toward your deductible. To your insurance carrier for previously completed self-pay visits if you choose to date. The coverage. The company, but I do not wish the Provider to submit a claim to my carrier. The my health insurance plan. The surance company. The contents of this form that sessions in 1 month - \$350 and the sessions in 1 month - \$650 sion per business day for 1 month - \$1,500 universents to participate in the Patient Self Pay program. The contents of this form that it is greenent before receiving the described services. I have been to pay for the services in full or within the guidelines of a formally established ider. Date	
Estimated Cost Per Visit:		
Single Session - Evaluation is \$15	60 / Follow up is \$100	
• .		
Onlimited Package - Up to ONE se	equested that your or your dependent's physical therapy visits be coded as "self-pay" services. By signing this form, knowledging that you understand that the Provider will not be billing any insurance carrier for services provided, and e subject to the self-pay policies and guidelines of the Provider as listed below. Self-Pay Program is not available to patients covered by Medicare. aware that: If-pay services must be paid in full on the date of service. ou have health insurance that you are electing not to bill for services, you will likely not be reimbursed by your carrier be able to apply these payments toward your deductible. Provider will not submit billing to your insurance carrier for previously completed self-pay visits if you choose to oke your self-pay status at a later date. sek the appropriate box below. ent does not have health insurance coverage. covered by a contracted insurance company, but I do not wish the Provider to submit a claim to my carrier. ead, I elect to pay for all services out of pocket. rapist/Facility does not participate in my health insurance plan. rice is not covered by my health insurance company. -covered Service: Type of Service: Est. Cost per Visit: Cost Per Visit: ngle Session - Evaluation is \$150 / Follow up is \$100 Iver Package - Up to FOUR 45 minute sessions in 1 month - \$350 old Package - Up to EIGHT 45 minute sessions in 1 month - \$650 Inlimited Package - Up to ONE session per business day for 1 month - \$1,500 below, I attest that I meet the requirements to participate in the Patient Self Pay program. The contents of this form to explained to me, and I have voluntarily signed this agreement before receiving the described services. I have been he estimated costs will be. I agree to pay for the services in full or within the guidelines of a formally established lan between myself and the Provider.	
have been explained to me, and I have vol	untarily signed this agree ree to pay for the services	ment before receiving the described services. I have been
Patient/Guardian	Date	
Printed Name of Responsible Party	Relation	ship to Patient