

Statement of Patient Financial Responsibility

Patient Name: _____

Parent/Guardian Name (if patient is a minor): _____

Life Health Strength Physical Rehabilitation appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to have services at Life Health Strength Physical Rehabilitation continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Life Health Strength Physical Rehabilitation, for providing healthcare services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Life Health Strength Physical Rehabilitation, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ Date _____

Right to Self-Pay

I do not have health insurance or I elect not to use my health insurance benefits for treatment and I will be financially responsible for payment of services rendered here at Life Health Strength Physical Rehabilitation. I agree to pay Life Health Strength Physical Rehabilitation for the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature _____ Date _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for three consecutive appointments or cancel for a total of four appointments, I may be discharged from care. I understand that I am welcome to return to Life Health Strength Physical Rehabilitation upon discharge, but will be re-enrolled and billed as a New Patient.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature _____

Date _____