GREENRIDGE
Physical Therapy
& Wellness

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Green Ridge Physical Therapy and Wellness. We bill your insurance as a courtesy to you, but you are ultimately responsible for paying for your care. Your insurance may require authorization for subsequent visits, and if you choose to be seen without authorization you may be responsible for the full cost of the visit. Call the number on the back of your insurance card to find out what your physical therapy benefits and what your authorization requirements are.

If you do not have insurance, we offer a discount if you pay at the time of service. That discount is not available retroactively or if we bill any insurance.

Please read carefully and initial each space below to show your understanding and agreement to these key points:

_____ I authorize direct payment from my insurance carrier to GRPT. I will update GRPT immediately if there is any change to my insurance or to my contact information. I understand that if a change in insurance is not reported to GRPT immediately, there may be a lapse in coverage that can cause me to be responsible for the full cost of visits during that lapse.

_____ GRPT will attempt to verify my current insurance benefits, but verification of eligibility, benefits, or authorization is not a guarantee of payment. Furthermore, I understand that the information we receive from your insurance carrier may be incomplete or inaccurate. I understand that I am responsible for knowing my specific insurance plan coverage. I understand that I am responsible for paying for the care I receive regardless of what my insurance plan does or does not pay.

_____ I understand that depending on my specific insurance plan that I may owe a co-pay, deductible, or percentage of charges. If care is authorized by my insurance, I may still owe these expected payments depending on my insurance coverage. Co-payments are due at each visit. GRPT will refund any overpayment when my therapy is finished. I understand that I am responsible for all charges that are not paid by my insurance. Any outstanding balances remaining after 60 days from the time of service will be subject to a 1.5% monthly interest charge (18% annually). For any returned checks there will be an NSF assessment of $35.

_____I understand if I cannot come to a scheduled appointment, I need to call the office 24 hrs. prior to the appointment otherwise there will be a $65 late fee. Failure to call or show for an appointment will result in a $65 No Show fee.

_____ I have read this agreement and understand that regardless of my insurance benefits or lack thereof, I am responsible for payment of my account. I agree to pay for costs associated with third party collections and reasonable attorney fees if I fail to pay my bill within six months of my last visit.

PRINT PATIENT NAME: _____

PATIENT SIGNATURE: _____ DATE: _____

PARENT/GUARDIAN must sign if patient is under 18 years of age