Pritchette Physical Therapy
orthopedic & sports rehabilitation
aquatic therapy • sports performance

INSURANCE BENEFITS WITH ESTIMATED PATIENT FINANCIAL RESPONSIBILITIES

PATIENT NAME:_____

INSURANCE:_____EFFECTIVE DATE:_____

COVERAGE SUMMARY:_____

DEDUCTIBLE:_____OOP:_____

PT. RESP TOWARD DEDUCTIBLE:_____

COPAY/COINSURANCE:_____

OF VISITS ALLOWED:_____# OF VISITS USED:_____

ESTIMATED PT. RESPONSIBILITY PER VISIT:_____

THIS FINANCIAL AGREEMENT IS BASED ON COVERAGE INFORMATION PROVIDED BY YOUR INSURANCE CARRIER. PRIOR TO TREATMENT STARTING, PRITCHETTE PHYSICAL THERAPY VERIFIES YOUR INSURANCE BENEFITS WHICH IS SUBJECT TO CHANGE ONCE THE CLAIM IS RECEIVED AND PROCESSED. YOUR INSURANCE CARRIER RESERVES THE RIGHT TO REVIEW EACH CLAIM UPON RECEIPT AND WILL PROCESS IT ACCORDINGLY. THIS IS AN ESTIMATED AMOUNT DUE WHICH COULD EITHER BE LOWER OR HIGHER THAN THE INFORMATION LISTED ABOVE AND IS THE PATIENT'S RESPONSIBILITY TO PAY. IF YOUR INSURANCE TERMINATES OR DENIES PAYMENT, FOR ANY REASON, FOR THE CARE RECEIVED AT PRITCHETTE PHYSICAL THERAPY, IT IS ULTIMATELY YOUR RESPONSIBILITY TO PAY THE UNPAID BALANCE FOR SERVICES RENDERED. IF YOUR INSURANCE CHANGES, IT IS YOUR RESPONSIBILITY TO ENSURE THAT PRITCHETTE PHYSICAL THERAPY HAS THE CORRECT INSURANCE INFORMATION IN ORDER TO SUBMIT SERVICES WITHIN 30 DAYS. IF YOU NEGLECT TO SUPPLY THE NEW INSURANCE INFORMATION, THIS AGREEMENT WILL BE NULL/VOID AND YOUR FINANCIAL RESPONSIBILITY WILL BE BASED ON YOUR INSURANCE'S CONTRACTED RATE. IT IS YOUR RESPONSIBILITY TO PROVIDE PRITCHETTE PHYSICAL THERAPY WITH YOUR POLICY AND GROUP NUMBERS.

PRINT PATIENT NAME:_____

RESPONSIBLE PARTY SIGNATURE:_____

RELATIONSHIP TO PATIENT:_____

BILLING QUESTIONS CAN BE DISCUSSED WITH RUTH, BILLING MANAGER @ 480-601-4997 OR VIA EMAIL @ BILLING@PRITCHETTEPT.COM

THANK YOU

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