PAYMENT AGREEMENT

MEDICARE

We accept Medicare assignment and we will bill Medicare. We will bill your secondary insurance for you if applicable. Medicare pays 80% of the approved amounts on the first $2080 of physical therapy and speech therapy per calendar year (after you have met your deductible). Medicare does not allow us to write off any portion of the 20% co-pay or the deductible; the balance is your responsibility. Any amount over the $2080.00 maximum benefit cap is your responsibility in this setting*.

I understand that I am responsible for amounts not covered by Medicare up to the maximum allowed by the Medicare fee schedule. I understand that I am responsible for all fees over the $2080.00 benefit cap.

I request that payment under the medical insurance program be made to Peninsula Physical Therapy on any bills for services furnished me during the effective period of this authorization. I authorize Peninsula Physical Therapy to release to the Social Security Administration or its intermediaries any information needed for this claim or any related Medicare claim. I further permit a copy of this authorization to be used in place of the original.

Signature _____ Date: _____

HEALTH INSURANCE

We will bill your medical insurance for you. Our fees fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. However, not all services are covered by benefit of all contracts. Any fees not covered by your insurance are your responsibility. If your insurance requires that you make a co-payment, please make your payment at the time of your visit. We accept cash, checks, Visa or MasterCard.

I hereby authorize and request my insurance company to pay directly to Peninsula Physical Therapy the amount(s) due on my claim for services rendered to me or to my dependent. I authorize the release of my physical therapy records as needed to process my insurance claim. I understand that I am responsible for all charges whether they are paid by insurance or not.

Signature _____ Date: _____

MOTOR VEHICLE OR OTHER ACCIDENTS

As a courtesy to you, we will bill your Personal Injury Protection (PIP) insurance. We will not bill any third parties or third party insurance. Once your PIP coverage is exhausted or denied, we will bill your health insurance.

I understand that my PIP insurance will be billed. After PIP coverage is exhausted, I understand that my health insurance will be billed and I have completed the health insurance section or this form. I understand that I am responsible for any balance that remains on my account. I authorize the release of my physical therapy records as needed to process my insurance claim. I hereby authorize my insurance company to pay directly to Peninsula Physical Therapy the amount(s) due on my claim for services rendered.

Signature _____ Date: _____

NON AUTHORIZED VISIT

I understand that in order for my insurance carrier to consider payment for any visit, an authorization is required from my Primary Care Physician. I further understand that non-authorized visits are my financial responsibility according to my insurance policy.

*I am seeking care from Peninsula Physical Therapy knowing that an authorization **HAS NOT** been received from my Primary Care Physician at the time of this visit. I therefore understand that I **MAY** be financially responsible for any charges incurred related to this or any visit not covered by an authorization.*

Signature _____ Date: _____

WORKER'S COMPENSATION CLAIM

It is your responsibility to provide your claim number along with the name and address of the insurance carrier to Peninsula Physical Therapy for billing purposes. If your worker's comp insurance carrier does not accept your claim, we will bill your health insurance for our services. Be sure that portion of the registration is completely and absolutely filled out.

I understand that if my claim is NOT paid by the worker's compensation insurance or by my health insurance I am responsible for all charges. I authorize the release of my physical therapy records as needed to process my insurance claim.

Signature _____ Date: _____

NON INSURED VISITS

I acknowledge that I am financially responsible for all physical therapy charges. I either do not have medical insurance or I am seeking care and requesting that your Clinic not bill my medical insurance.

Signature _____ Date: _____

FINANCIAL RESPONSIBILITY

I agree to pay for all services provided. I acknowledge and accept that it is my personal responsibility for payment in full for billed charges even where Peninsula Physical Therapy has assigned partial benefits from government programs and insurance companies. I acknowledge failure to pay my financial obligations to Peninsula Physical Therapy may result in the referral of account(s) to a professional collection agency. In the event of any dispute regarding payment, I agree to pay all collection costs or fees including but not limited to interest at the highest rate allowable under the law and attorneys' fees in the event legal action is taken.

Phone Authorizations: You hereby grant permission and consent to us, our assignees, and third party collection agents: (1) to contact you by telephone at any telephone number associated with you, including wireless numbers; (2) to leave answering machine and voicemail messages for you, and include in any such messages information required by law (including debt collection laws) and/or regarding amounts owed by you; (3) to send you text messages; (4) to use prerecorded/artificial voice messages and/or an automatic dialing device in connection with any communications made to you or related to your account.

I understand that this agreement indicates that I accept my responsibility to pay these in accordance with the payment terms set forth by this provider. I understand that I have the right to ask about costs before services are provided to me and that costs are deemed liquidated once the provider has prepared and sent the first invoice to me.

Signature _____ Date: _____

Print_____