Patient Name: _____

PATIENT WAIVER

Thank you for choosing **Integra Physical Therapy** for your present ailment. To ensure you receive the best possible service, the following information is provided to enhance your understanding of your rights and responsibilities as our patient.

Insurance information

- ✓ Please be aware of your insurance benefits and physical therapy coverage. Physical Therapy is a specialty service and generally differs from standard medical benefits. It is your responsibility to verify your present benefits (deductible, co-insurance, co-pay, etc.) through your insurance carrier.

- ✓ Your insurance coverage is an arrangement between you and your carrier. If you have questions regarding your insurance benefits, please call your insurance company's customer or member service department (phone number is usually located on the back of your insurance card).

- ✓ Upon treatment, you will be responsible for any amount not covered by your insurer (unless a financial agreement was made between you and the manager), including, but not limited to deductibles, co-insurance and co-payments, as stated in your benefits package. In addition, all co-payments will be collected at the time services are rendered.

- ✓ If your insurance carrier denies any part of your claim, or if you or your physician would elect to continue therapy past the approved period of time or authorized visits, you would be responsible for any charges incurred beyond that point of time. If this would happen, you would be eligible for a discount for self-payment and a specific payment plan can be set up between you and Integra Physical Therapy.

- ✓ Integra Physical Therapy must receive payment within 30 days after your first billing statement. If you are not able to make payments, financial arrangements can be made by calling our office or speaking with your therapist.

    - I have read the above statement. It is my understanding that I am financially responsible to Integra Physical Therapy for providing therapy services to me, or the above patient
      (Pt. Initials) _____

    - I authorize my insurer to pay any benefits directly to Integra Physical Therapy and **I AGREE TO PAY** Integra Physical Therapy **THE FULL AMOUNT OF ALL BILLS INCURRED** by myself, or the above named patient. If applicable, I will pay any amount due after payment has been made to Integra Physical Therapy by my insurance carrier (co-insurance/deductible etc).
      (Pt Initials) _____

- ✓ I authorize Integra Physical Therapy, through its appropriate personnel to Evaluation and Treat the above named patient relating to the diagnosis below by a licensed Physical Therapist:
  Diagnosis: _____(Pt. Initials) _____

- ✓ I authorize Integra Physical Therapy to release any information acquired during the course of treatment for the above named patient, to the appropriate agencies, while staying in compliance with HIPPA laws of 2004 (See form). (Pt. Initials) _____

Patient Signature: _____ Date: _____

Guarantors/Guardian (If patient is a minor): _____ Date: _____