Financial Policy Statement

CREST PHYSICAL THERAPY

CREST PHYSICAL THERAPY calls your insurance company in advance of your treatment to verify what they will and/or will not cover, and what your responsibility may be. Please realize that the information they give us is just an "estimation" of your benefits and not a guarantee they will pay that way. All payments you make at the facility are only intended to go towards your total patient share and may not be your final responsibility. If at any time during your therapy, your insurance changes, please inform facility front desk as soon as possible.

Since *CREST PHYSICAL THERAPY* is not an in-network provider, your insurance company may be sending all Payments and Explanations of Benefits directly to you. The explanation of benefits itemizes what was covered/paid to both the patient and to *CREST PHYSICAL THERAPY*. *CREST PHYSICAL THERAPY* will send a letter/bill asking for any further amounts due for that billing period, if any. You may also receive an automated reminder call for any balance due at the end of your treatment. If at any time you feel your insurance company processed your claim incorrectly, please contact them directly.

By signing below, you agree to forward the payment and Explanation of Benefits to *CREST PHYSICAL THERAPY*. Without the Explanation of Benefits, the payments may not be applied correctly, which could result in you being sent a bill for your visits.

Please be advised that you must make a co-insurance payment for each visit with *CREST PHYSICAL THERAPY*. Your co-insurance amount is $_____, as per your insurance company. By signing below, you agree to make your co-insurance payment on each visit. We accept Visa, MasterCard, Discover, American Express, Checks, Money Orders, and Cash.

Every employee on the *CREST PHYSICAL THERAPY* team is committed to delivering exceptional service to our customers; providing the premier, community based rehabilitation services that return patients to their active lifestyle. Thank you for choosing *CREST PHYSICAL THERAPY*.

By signing below you are stating that you have read and understand this form:

_____ _____

SIGNATURE DATE

_____

PRINT NAME

OFFICE USE ONLY

Intake Reviewed by: _____ Date: _____

