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2018 Patient Responsibility Agreement

Patient Name: ____ Date: _____-______-______

We bill all insurance payers although we may not be contracted with all insurance companies. If we are a network provider for your insurance company, they will pay for our services at the negotiated rate and we will apply the appropriate payments and adjustments to your account. It is your responsibility to pay deductibles, co-payments or coinsurances. All out of network charges will be negotiated as discussed per this agreement.

If pre-authorization is required, it is the responsibility of the provider to initiate the authorization process. If the authorization is not approved at the time of your evaluation, you will be given the option to have the evaluation without authorization and risk denial and financial responsibility or reschedule until authorization is approved. Upon the completion of your evaluation, we will bill your insurance.

Definitions:

Deductible- The deductible amount depends upon the type of plan that you have with your insurance carrier. This is the amount that must be paid by you prior to your insurance making any payments on your behalf.

Copayment- is a predetermined fee an individual will pay for health care services, in addition to what the insurance covers. For example, some insurance payors require a $10 copayment for each office visit, regardless of the type or level of services provided during the visit.

Coinsurance-is a predetermined percentage an individual will pay for health care services, in addition to what the insurance covers. For example, some insurance requires a 20% coinsurance. We will bill your insurance and apply all payments and adjustments. You will be responsible for the 20% that your insurance does not cover.

We have determined the following to be your responsibility per the phone call to your insurance company. **THIS IS NOT A GUARANTEE OF PAYMENT.**

Deductible: In______ out_______

Amount: $______________ has______ hasn't________ been met for your benefit period.

Copay: _______________ per visit

Coinsurance: ___________%

Payments will be accepted as follows for your treatment:

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DEFY
THERAPY & WELLNESS

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Patient Acknowledgement:

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Office Staff: ____ **Date:** ______-______-__________