

Financial Policy

As the patient you are responsible for knowing the policies and procedures of your insurance plan, including pre-certification, limitations, maximum benefits, co-payments, etc. As a courtesy, we will submit all primary insurance billing. Arrangements may be discussed for secondary insurance billing submission. Any remaining balance such as co-insurance, deductible, etc, is your responsibility. We accept cash or check for payment. If you have any questions, please speak to a member of our office staff. Thank you for understanding our financial policy.

- _____ I authorize use of this form on all of my insurance submissions.
- _____ I authorize release of information to my insurance companies.
- _____ I authorize payment directly to Atlantic Physical Therapy Center.
- _____ I authorize Atlantic Physical Therapy Center to act as my agent in obtaining payment from my insurance company.
- _____ I permit a copy of this authorization to be used in place of the original.
- _____ I understand that I am responsible for my bill.

I have read the financial policy above. I understand and agree to this policy.

Patient signature _____ Date _____