Physical Rehabilitation Group, LLC

Financial Agreement

Patient Name: ________________________________ Date: ___________________

I, ________________________________ understand that I am responsible for:

Deductible amount: __________

Co-payment/co-insurance amount: __________ per visit.

_____ (please initial) In the event any portion of the professional services are not covered by one or more of my insurance policies, I understand I will be billed and am responsible for that amount. **PLEASE NOTE THAT THIS IS AN ESTIMATE PRIOR TO CLAIM PROCESSING**.

I have been informed and am in agreement with the statement above:

____
Patient Signature

It is the policy of this practice to collect charges for services as they are rendered, unless prior arrangements are made and credit is established.

By my signature below, I hereby certify that my insurance benefits have been explained to me and I fully understand the terms of my policy. I also understand that I am responsible for making payments as services are rendered until my deductible and/or out-of-pocket expense has been satisfied. I authorize my insurance benefits to be paid directly to **Physical Rehabilitation Group, LLC** and agree that I am financially responsible for any amounts not covered and/or paid by them.

I understand that if I do not pay the full amount as agreed to above, **Physical Rehabilitation Group, LLC** may turn my account over to a Collection Agency after notification by letter.

Patient or Authorized Person:

____________________________________ ____________________________________
Signature Print Name

____
Date

Corporate Office – P.O. Box 3408, Irmo, SC 29063 (P) 803-732-5887 (F) 803-732-5997