Verified by:____________________ Date:_____________ Therapist:______________

Allied Physical Therapy
your allies for life

Clinic Policy and Cost Estimate

Patient Name: ______________________ DOB: ______________________
Primary Insurance: ______________________ Secondary Insurance: ______________
Effective Date: ______________________ Verified by phone or web
Precertification required: YES NO Limits: # Visits/Max $ amount
Medicare Supplement: YES NO Pays: Deductible YES NO Coinsurance: YES NO

Deductible:	Amount remaining of deductible:	
Maximum out-of-pocket:	Amount remaining on out-of-pocket:	
Your co-insurance after deductible is met:	Co-Pay due at each visit:	

Please read the following information regarding payment for professional services. Your initials and signature below indicate that you have read, understand, and agree to the policies of Allied Physical Therapy (APT) regarding payment for professional services.

________All co-pays and estimated patient responsibilities are due at the time of service. You may pay with cash, check,money order,debit or credit card or Care Credit. A returned check is subject to a $20 service fee.

________ The amounts shown above are estimates only. Your final charges and/or financial responsibility may differ after submission to insurance.

________ We have verified your participation of insurance as a courtesy. **This is never a guarantee of payment**. You are responsible for 1) verifying your deductible, co-insurance/copay, and out of pocket amounts with your insurance carrier 2)understanding differences in your insurance plan, plan benefits, or out of pocket amounts met/unmet at the actual time of visit 3) being aware of any precertification requirements imposed by your insurance carrier.

_________ I understand the physicians of Allied Physicians of Michiana LLC (APOM) have financial interest and medical practice ownership in Allied Physical Therapy LLC. I understand that I may choose to be referred to another facility or healthcare entity. For further information contact APOM (574) 251-2103 or APT (574) 968-2851

_________ **Medicare patients only**… Please alert the front desk if you have completed therapy elsewhere this calendar year. Medicare has an annual cap of $1980 combined therapy, regardless of location.

_________ **Direct access patients only:** A physician referral will be required within 28 days of initiating your treatment. If you do not obtain a physician referral, we will file your claim with your insurance company and you assume financial responsibility for any treatment not covered.

For patients 17 years and younger, a parent or legal guardian must accompany and sign below.
My signature indicates I understand the above estimates and policies.

______________________________ ______________________
Signature Date