Country Roads
PHYSICAL THERAPY

FINANCIAL POLICY
PATIENT RESPONSIBILITY AGREEMENT

Please select only ONE of the following options:

I agree to pay:

☐ co-ins at each visit (example: 80% / 20%)

☐ co-ins at the beginning of each week

☐ co-ins at the end of each week

☐ set up a monthly payment agreement (may be required to speak to the billing department)
Agreement: $_____ per month on the _____ of each month, beginning _____.
Authorized by: _____ Spoke to _____ at the billing department.

If you are covered under a health insurance policy, responsibility is not transferred to patient balance until an explanation of benefits is received for each date of service. Patient responsibility balance will change as your insurance company pays on each date of service.

All Co-Pays Are Due At Time Of Service

If you are covered under a health insurance policy, we will submit your claim for you, if the current and correct information is provided at the time of service.

_____ _____

Please Print Patient's Name | Account #

_____ _____

Patient / Guardian Signature | Date