

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Woodstock Physical Therapy
1816 Eagle Drive, Bldg 100, Ste C
Woodstock, GA 30189

Patient Name: _____ **Date of Birth:** _____

In consideration of the services provided at the Practice identified above:

Please initial each statement:

_____ *If you provided us with insurance information, you are obligated to pay all in-network co-payments and deductibles at the time services are rendered. You will subsequently be invoiced for any additional amounts which are not paid by your Insurer. You have an affirmative duty to make sure that payment and/or correct information for payment is given to the Practice for reimbursement of services provided.*

_____ **I hereby assign** all medical provider benefits payable (i.e. "Payor: Insurance Coverage, Medicare, Medicaid, Social Security, etc.) and related rights existing under the Payor coverage that I have identified or will identify in connection with the services provided directly to Facility.

_____ **I hereby acknowledge** and give my express permission for Woodstock Physical Therapy to release all my patient health information, including privileged information (i.e. mental health, alcohol/drug abuse or HIV/AIDS), for payment purposes.

_____ **I understand** that any payment received by Facility for this period may be applied to any unpaid bill(s) for which I am liable.

_____ **I understand** that different insurances have different requirements for payment including, but not limited to, pre-certifications, referrals, authorizations or that the services be medically necessary.

_____ **I understand** that it is **my obligation** to know my Payor's requirements and ensure that they have been fulfilled.

_____ **I understand and agree that I am financially responsible for any charges not covered by this assignment and agree to pay the Practice the full balance that is not reimbursed by my medical provider benefits (certain exceptions may apply for Medicare Beneficiaries).**

_____ **I understand** that any and all balances assigned as patient responsibility may be subject to both internal and external collection efforts, as well as credit reporting to the three major credit bureaus if not paid in a timely manner.

_____ **I understand if a scheduled appointment is missed without the minimum 24 hour notice, I may be charged a \$25 "no-show" appointment fee. This is my sole responsibility and can not be billed to my insurance.**

Printed Name of Patient/Guarantor

Signature Patient/Guarantor

Date _____