Insurance Company Information

1. Primary Insurance Company Name	2. Secondary Insurance Company Name
Policy Holder Date of Birth	Policy Holder Date of Birth
Policy Holder Employer Policy Holder SSN	Policy Holder Employer Policy Holder SSN
Policy Number Group Number	Policy Number Group Number
Address	Address
City, State & Zip Code	City, State & Zip Code
Telephone Number	Telephone Number
Relationship to the Patient (circle one)	Relationship to the Patient (circle one)
Self Spouse Child Parent Other	Self Spouse Child Parent Other
Date Reviewed Parent Initials	Date ReviewedParent Initials
PATIENT WAIVER	
Patane & Associates Physical Therapy, LLC, appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance company. However, you are ultimately responsible for payment of your bill.	
You are responsible for payment of any deductible and co-payments/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, of if you or your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. Plan benefits do not guarantee payment made by the insurance company.	
I have read the above policy regarding my financial responsibility to Patane & Associates Physical Therapy, LLC for providing rehabilitative services to me or the patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Patane & Associates Physical Therapy, LLC. I agree to pay Patane & Associates Physical Therapy, LLC the full and entire amount of all bills incurred by me or the patient; or if applicable, any amount due after payment has been made by my insurance carrier.	
In the event the account is not paid in full or satisfactory arrangements have been made within an allotted time frame, Patane & Associates Physical Therapy, LLC. reserves the rights to send my account to a collection agency and/or an attorney for collection of the owed balance. I agree to pay all costs incurred in collecting the amount due and any additional attorney commission fees and/or collection fees required by the collection agency.	
PATIENT SIGNATURE:	DATE:
GUARANTOR SIGNATURE:(If guarantor is not the patient)	DATE: