CAPE REGIONAL
Physical Therapy

Notice of Financial Responsibility

Cape Regional Physical Therapy 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 your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf.

You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible /coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. In some instances, we are "non-par" or out of network with some insurances. You may get an "EOB" (Explanation of Benefits) that you owe **Cape Regional Physical Therapy** that balance of the bill. Please call us and we will explain your financial obligation. **In the event that your insurance carrier sends you the payment for physical therapy, you are responsible for mailing or dropping off such payment to our office.**

At this time, we expect payment of your **copay** in the amount of $

I have read the above policy regarding my financial responsibility to **Cape Regional Physical Therapy** for providing rehabilitative services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to **Cape Regional Physical Therapy**. I agree to pay **Cape Regional Physical Therapy** the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Patient Name:
Signature:
Date: