Explanation of Insurance Benefits

Acct #:_____ **Date:**_____

CORE Provider:_____

For office use only

Patient Name: _____ Date of Birth: _____

Our records show that your primary insurance policy is with: _____

Effective Dates: _____ To _____

Authorization Required: ☐Yes ☐No

Auto Accident/Injury: ☐Yes ☐No

For your convenience, we have called to inquire about your physical therapy benefits. The following represents information provided to us by your carrier and should be considered only as a quote. It is possible, that when your claim is submitted for processing, the amounts represented below may be different. We encourage you to contact your insurance carrier directly to confirm all benefits.

Reimbursement for physical therapy services is paid at _____ % of the allowed amount. The remaining _____ % is the patient responsibility. Your deductible is $ _____ and $ _____ has been met year-to-date.

Your co-pay for each physical therapy visit is $ _____

Additional information: _____

If you have a secondary insurance we will bill one second or supplemental insurance as a courtesy. Please be aware that payment may be denied for services, as we are not contracted with all secondary insurances. If you do not have a secondary or supplemental policy, payment is due after primary insurance has processed your claim. Any amounts not covered by a second or supplemental policy will become the patient's responsibility.

Have you had any type of physical therapy within the last year? ☐Yes ☐No

Have you had any services this year by any Home Health Agency? ☐Yes ☐No

I understand and agree to the above information.

Patient Signature: _____ Date: _____

Last Revision Date: 6.22.2018