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Notice to Out-Of-Network Patients

This notice is to inform you that I am a **non-participating provider** with your insurance company. I will be happy to courtesy bill your insurance company for you; however, you will be responsible to pay for your visits in-full at the time services are rendered. Your insurance company will then directly reimburse you for any out-of-network benefit that you are entitled to.

Financial and Insurance Responsibilities:

With my signature, I acknowledge that I agree to pay for my treatment at the time of service, by cash, by check, or charge card. I understand it is my responsibility to call my insurance company ahead of time to obtain any pre-authorization that is necessary, and to obtain an estimate of my benefits/limitations. I understand that my therapist is **NOT** contracted with my insurance company. I understand that my therapist will courtesy bill my insurance company for me so that my insurance company may reimburse me any monies allowed to me under my "out of network" coverage. I understand that **Women's Health Physical Therapy** cannot make any guarantees or estimates regarding what reimbursement my plan allows.

I authorize Brande Moafftt, MPT, PRPC/ Women's Health Physical Therapy to furnish my insurance company with any information/medical records that may be requested concerning payment of benefits.

Fees: $165 for initial evaluation
$ 140 for all 1-hour follow-up appointments.
$ 50.00 for no-show/late cancellations with less than 48 hours notice.
Late arrivals will be charged the fee for the entire visit.

I have read the above information and I consent to physical therapy evaluation and treatment.

Print Name: _____Date:_____

Patient/Guardian Signature: _____