Insurance and Financial Policy

- As a courtesy to our patients with health insurance coverage, we contact your insurance carrier to obtain authorization and verification of your coverage. We will provide you with an estimate of the out of pocket cost that you may expect during your treatment.
- Please understand that this is only an estimate and your insurance company ultimately determines the amount you will be liable for at the time claims are processed.
- Co-pay, co-insurance and deductible amounts are due at the time of service unless prior arrangements are made with Core Performance Physical Therapy.
- In the event that your insurance company denies your claim, you understand that you are liable for the full cost of treatment.
- We strongly encourage you to contact your insurance company at the start of your treatment to verify that the benefits provided are correct.
- If you find discrepancies with our information or have any questions concerning your coverage, please contact us immediately.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Core Performance Physical Therapy to furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

WORKER'S COMPENSATION: If you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for serviced rendered to you.

FINANCIAL POLICY: We bill your personal insurance carrier solely as a courtesy to you. You are responsible for your bill. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment to us within 60 days, the balanced owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to us. If formal collection procedures become necessary, you will be responsible for additional costs incurred. Your insurance benefits as quoted to us by your insurance carrier have been reviewed with you. We assume no liability for any errors made by your insurance carrier in the quotation. We have reviewed these benefits with you and you agree to pay your portion of this bill.

The above information has been read and explained to me. I understand my responsibility for the payment of my account.

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Patient/Parent/Guardian Signature *Date*