UNION PHYSICAL THERAPY

Agreement to Self Pay/Waiver for Insurance Exclusions

Name of Patient:

Union Physical Therapy (UPT) believes that your insurance plan may not pay for your treatment(s) or service(s), which may result in direct costs to you. You are responsible for verifying your health plan coverage with your insurer. This form is to help you make an informed choice about whether or not you want to receive treatment or services, knowing that you might have to pay for them yourself. If needed, please ask for an **ESTIMATED COST** for the items or services you may receive at UPT.

Reasons for Signed Waiver: Please initial next to the checked box(es).

_____ ☐ **Self Pay -** I am not covered under a health insurance plan and/or choose not to utilize my health insurance plan. I choose to receive and to pay for the therapy services out of pocket. I understand I will receive a 35% discount off the FULL AMOUNT of the visit total.

_____ ☐ **No referral/Rx -** I have presented to my appointment without proper referral or prescription from my referring physician. I understand that my carrier **requires** a prescription or referral as proof of medical necessity. If my carrier denies payment based on the lack of prescription or referral, I agree to pay for services rendered during the period of lapsed prescription/referral.

_____ ☐ **Pending Authorization -** I am aware that my insurance coverage **requires** prior authorization. At this time, authorization will be or has been submitted however it is still pending and cannot be verified. If my carrier denies the authorization, I agree to pay for services rendered during the unauthorized date(s) of service.

_____ ☐ **Not Eligible/Out(Max) of Benefits** - I am aware that my insurance coverage is not eligible on this date(s) of service and / or I agree to pay for any services that exceed my plan limits. I understand UPT will not file claims to my insurance during this period and network adjustments will not be applied. I choose to receive and to pay for the therapy services out of pocket.

_____ ☐ **3rd Party / Attorney Liens -** I have been involved in an accident that resulted in my injuries and the responsible party will be reimbursing me for the services I receive as part of recovery or I have retained an Attorney to assist in my settlement. I understand that UPT will not accept payment or deferred payment from either a 3rd Party and/or Attorney Lien. I agree to pay for all services related to this claim and I am ultimately responsible for the full payment of all services rendered.

_____ ☐ **OTHER:** _____

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I understand and accept that I am financially responsible as indicated above with my initials, for services rendered at Union Physical Therapy.

Date: _____ **Signed: _____**
Signature of patient or responsible party

Date: _____ **Signed: _____**
Signature of provider's office representative