Wholistic Physical Therapy

# *BENEFIT VERIFICATION AND PAYMENT PLAN AGREEMENT*

**Patient Name:** **Act #:** **Verified By:**

**Insurance:** **COB:** **Case #:** **RT Code:**

**Contract #:** **Group #:** **Network:**

**Call Ref. #:** **Rep. Name:** **Date Verified:**

## Benefit Limitations Discalimer

As a courtesy, Wholistic Physical Therapy has verified your benefits, they are quoted below. If you have had Physical Therapy at another Physical Therapy Center or Home Health Care, all claims must be processed by your Insurance for accurate accumulations. **If you are currently in Home Health Care, Out-Patient Physical Therapy is not a covered benefit**. If you have recently finished Home Health Care, **the HHC Episode must be formally discharged prior to starting Out-Patient Physical Therapy treatment.** If you have had Physical Therapy at another Physical Therapy Center, and/or HHC, it is your responsibility to know the number of visits used and balance remaining. If you do not know this information, we recommend that you obtain this information prior to starting your treatment. After your insurance company deems your care as medically necessary, and if benefits are available at the time of service, your policy limits for Physical Therapy are listed below:

**Policy Type:** **Effective Dates:** ***TO:***

**Authorization Requirement:** **For authorization call/online:**

| IN-NETWORK BENEFITS | TOTAL | MET | REMAINING |
|---|---|---|---|
| DEDUCTIBLE (DED) | | | $ 0.00 |
| OUT OF POCKET | | | $ 0.00 |
| COINSURANCE (CI) | 0% | COPAY | |
| *APPROXIMATE cost per visit (when DED/CI applies):* | | Initials_____ | |
| PT/OT AVAILABLE PER: | TOTAL | USED | REMAINING |
| | | | 0 |

| OUT-OF-NETWORK BENEFITS | TOTAL | MET | REMAINING |
|---|---|---|---|
| DEDUCTIBLE (DED) | | | $ 0.00 |
| OUT OF POCKET | | | $ 0.00 |
| COINSURANCE (CI) | 0% | COPAY | |
| *APPROXIMATE cost per visit (when DED/CI applies):* | | Initials_____ | |
| PT/OT AVAILABLE PER: | TOTAL | USED | REMAINING |
| | | | 0 |

**Additional Benefit Details:**

***Patients with Flat Co-Pays Only:*** *Select a payment plan below*

***PLAN #1***
*Pay once a month -*
*Paying upon **first visit** of the month*
Initials_____

***PLAN #2***
*Pay once a week -*
*Paying upon **first visit** of the week*
Initials_____

***PLAN #3***
***Pay in full each visit***
Initials_____

**Telehealth A Covered Benefit?**

YES

**Patients with un-met: Deductibles, Co-Insurances, and with Secondary/Tertiary Policies: The claims will be billed to your insurance company(s). Remaining Patient Responsibiltiy will be billed to the Patient/Guardian.**

The benefit information outlined above was provided by a representative of your Insurance carrier. We do strongly recommend you confirm this information with your medical Insurance Company. Should the information they give you regarding your coverage differ in any way from what was outlined above, please bring this to our attention immediately. **If a Deductible or Co-Insurance applies to your policy, the quoted *cost per visit is only an estimation.* When additional patient responsibility is due after your claims have been processed, you will receive a statement. In the event of an overpayment, after all dates of service have been processed by your Insurance, a refund will be issued accordingly.** By signing below, I fully understand the above information and I am in agreement with the terms of my Insurance and the payment plan I have selected to take care of my personal financial responsibility.

_____ _____

Patient/Parent and or Guardian Signature Date Print Name Date

_____

Wholistic Physical Therapy Witness Date