C.H.O.O.S.E Physical Therapy, LLC

Billing Options: Please Choose Option 1 or Option 2

Option 1 - Self Pay

****For Patients who do NOT want to authorize C.H.O.O.S.E Physical Therapy, LLC., to do any billing to third party payers****

- I understand that if full payment is received on the day that services are provided, I and/ or my third-party payer will receive 50% discount for those services rendered. **This is 50% discount on C.H.O.O.S.E Physical Therapy, LLC., current fee schedule and not a negotiated fee scheduled by any insurance company or third-party payer.**
- I understand that I may bill my own insurance company with a receipt provided by C.H.O.O.S.E Physical Therapy, LLC.
- I understand that C.H.O.O.S.E Physical Therapy, LLC will NOT be participating in any direct billing for these services and cannot legally do so if a discount has been provided.
- I understand I may pay by check, credit card or cash following each session. **I understand that if I do not pay on the day of service the discount will not apply.**
- I understand if for any reason fees are not collected from the bank or credit card company, the discount will no longer apply, and I will be responsible for the full balance for that treatment and a fee that are applied by my bank or credit card company.

Patient Name: _____ Patient Signature: _____ Date: _____

Guardian Name: _____ Legal Guardian: _____ Date: _____

Option 2 - Assignment of Benefits:

****For Patients who authorize C.H.O.O.S.E Physical Therapy, LLC., to bill their insurance companies and/or other third-party payers***

- I have elected for C.H.O.O.S.E Physical Therapy, LLC., to bill my insurance company or other third-party payer directly.
- I am authorizing my medical benefits, or the patient's medical benefits (in the case of a minor or legal guardian as the responsible party) to be paid directly to C.H.O.O.S.E Physical Therapy, LLC., for services provided and the release of medical records to receive such payment.
- I understand that I am financially responsible for all charges regardless of the payment provided by the insurance company or other third-party payer. Payment for services is the responsibility of the patient or the patient's legal guardian.
- I understand that C.H.O.O.S.E Physical Therapy, LLC., verifies benefits as a courtesy to our patients and is not responsible for any misinformation provided by the insurance company or third-party payer.
- I understand that insurance companies/third-party payers may reimburse differently for different diagnosis codes or for pre-existing conditions. Diagnosis is provided by the physician and/or therapist based on the patient's current condition and will not be changed to modify or obtain insurance benefits

Patient Name: _____ Patient Signature: _____ Date: _____

Guardian Name: _____ Legal Guardian: _____ Date: _____