

**Blue Cross and Blue Shield Plans**  
**PRE-CERTIFICATION INSURANCE QUOTE**  
Advanced Physical Therapy Center of Stamford, LLC

As of \_\_\_\_\_ your insurance carrier “quoted” your benefits for physical and/or occupational therapy:

Deductible \$ \_\_\_\_\_ Co-insurance \_\_\_\_\_% Co-payment \$ \_\_\_\_\_ each visit  
Re-evaluation \$ \_\_\_\_\_ Initial evaluation \$ \_\_\_\_\_

Under Connecticut law and nationally established standards of practice, every patient must undergo an initial physical therapy evaluation and periodic re-evaluations. However, some BC/BS Plans (**Empire & Horizon**) will not cover initial evaluations or re-evaluations. Therefore, **you will be financially responsible for these charges**. Please be advised that your insurance carrier also states they “are not responsible for the accuracy of this information” and that this quote of benefits “is not a guarantee of payment”. **As a result, you will be held financially liable if your insurance company denies payment for services rendered at Advanced Physical Therapy Center of Stamford, LLC. Therefore, you may also want to verify your benefits by calling the 800 number on your insurance card.**

**LIMITATIONS**

In order to *minimize the chance* that your insurance company will reject your claim for therapy at our office, we request you provide the following information. Your policy may have specific limits of coverage and therefore, we ask these questions to help uncover any potential limitations with your specific insurance plan. **Failure to respond accurately may result in your insurance company denying payment, thus you will be help financially responsible for services rendered to you by Advanced Physical Therapy Center.**

- |   |       |    |
|---|-------|----|
| <b>1. Have you received physical therapy in 2010?</b>     | Yes   | No |
| If so, for the same diagnosis or body part?               | Yes   | No |
| How many visits did you attend?                           | _____ |    |
| <b>2. Have you received occupational therapy in 2010?</b> | Yes   | No |
| If so, for the same diagnosis or body part?               | Yes   | No |
| How many visits did you attend?                           | _____ |    |
| <b>3. Have you received chiropractic in 2010?</b>         | Yes   | No |
| If so, for the same diagnosis or body part?               | Yes   | No |
| How many visits did you attend?                           | _____ |    |

**Payment Policy:**

All payments (deductibles, co-insurance and co-payments) are due at the time of service.

\_\_\_\_\_  
Patient’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian’s Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
APTC Rep.

**DO NOT CASH CHECK:** IN THE EVENT YOU RECEIVE PAYMENT DIRECTLY FROM BLUE CROSS/BLUSE SHIELD, YOU **MUST SURRENDER THE CHECK AND COPY OF THE “EXPLANATION OF BENEFITS”** TO OUR OFFICE IMMEDIATELY. FAILURE TO PROVIDE INSURANCE CHECKS WILL MAKE YOU ACCOUNTABLE FOR FULL PAYMENT OF ALL CHARGES OR YOU WILL BE HELD LIABLE FOR ALL TAXES AND POSSIBLE LEGAL PROSECUTION.