

Self-Pay Agreement

Advanced Physical Therapy Center of Stamford, LLC

Patient: _____ Date: _____

_____ I do not have or have exhausted my insurance coverage.

_____ I do not wish to submit to my insurance company.

_____ I have not yet met my deductible of \$_____.

_____ My insurance does not feel my treatment is medically necessary and will not pay for services.

_____ My insurance benefits are currently suspended pending authorization or the outcome of a hearing or appeal.

_____ I am pursuing legal proceedings to cover my medical expenses.

_____ I am not a U.S. citizen and I plan to submit to my insurance company on my own.

I UNDERSTAND AND AGREE TO:

_____ Pay in full on each day of service.

_____ Pay on each day of service with a _____ ppd.

_____ Pay \$_____ on each day of service as a partial payment and continue to pay \$_____ per week when I am discharged until the balance is PAID IN FULL.

PAYMENT POLICY:

The Advanced Physical Therapy Center of Stamford, LLC (APTC) requires payment at the time of service. It is not our policy to “wait for settlement” or for the out come of a hearing or insurance appeal.

Depending on the type and length of services rendered, it is estimated that each treatment session will be \$75.00 to \$180.00.

I understand and agree that I am ultimately responsible for full payment of services. I understand that a 1.0% monthly late fee will be added in addition to any and all collection fees (\$10.00), court fees (\$35.00) and or legal fees (up to \$1000.00) as applicable to resolve any unpaid balances.

_____ I received a copy of this agreement

APTC Representative: _____

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____