



**FINANCIAL AGREEMENT**

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Co-insurance and deductibles for services are due at the time services are rendered. We accept cash, checks, MasterCard, or Visa. Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1½ % per month.

We will gladly discuss your proposed treatment and answer any questions relating to your plan of care. We will answer any insurance question we can...

You must realize however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by those companies. This applies only to companies who pay a percentage (such as 50%, or 80% of “U.C.R.”) U.C.R. is defined as usual, customary and reasonable fees for this region. This statement does not apply to companies who reimburse based on an arbitrary “schedule” of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services and certain diagnoses they will not cover. If we inform you that a certain form of treatment is not covered and you choose to receive it anyway, you will be responsible for the entire charge for that portion of your treatment.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. You must inform us regarding any changes in your insurance coverage(s).

If you have any questions about the above information or any uncertainty regarding insurance coverage, **PLEASE** do not hesitate to ask us. We are here to help you.

**PATIENT’S CONSENT AND FINANCIAL RESPONSIBILITY**

I hereby authorize Professional Therapies, Inc. to obtain-release information needed to process insurance claims, coordinate my care with other care providers and/or to gather pertinent medical documents to insure my safety. I authorize Professional Therapies, Inc. to bill and to collect from my insurance companies. I understand that I have the right to revoke this authority at anytime by doing so in writing. I hereby consent to the treatment prescribed by my physician and understand that I am ultimately responsible for all bills generated from such treatment.

I have received a copy of the PTI Attendance Policies and Procedures and am willing to accept responsibility to follow these guidelines concerning attendance at therapy sessions.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_