THE PT PEOPLE
PHYSICAL, OCCUPATIONAL & SPEECH THERAPY

3300 South Street, Ste. 203 | Lakewood, CA 90805
Office: (562) 512-3320 | Fax: (562) 3817763

Patient Financial Responsibility Form

I, _____, hereby acknowledge and agree to the terms outlined in this Financial Responsibility Consent Form. I understand that Medicare is my primary insurance, and there will be a coinsurance percentage of 20%. This implies that I am personally responsible for 20% of the total incurred charges.

In the event that there is a secondary insurance, we will make every effort to bill them. However, if the secondary insurance denies the bill, Athelas, our designated billing entity, will send me the bill for the remaining balance.

I acknowledge and accept that I am responsible for the prompt payment of any outstanding balance not covered by insurance. I also affirm that I have been provided with an opportunity to ask questions and seek clarification regarding any aspects of this financial responsibility agreement.

By signing below, I acknowledge that I have read and understood the terms outlined in this form.

Patient's Full Name: _____

Date: _____

Signature: _____

Address:

_____

_____