# Insurance Verification Process at Physical Therapy Solutions

**In order for you to complete your initial evaluation appointment with us, you will need to fill out the items in the box below and bring this to us on your first visit, so that we know what to collect from you, if any.**

*Insurance companies have proven to be unreliable in sharing accurate information on patient benefits when PROVIDERS do a courtesy check. We have had too many experiences where our courtesy check led to patients being upset with us for billing on inaccurate information we were given by their health insurance.*

Because our priority is to establish the **best** working relationship with all our patients, we no longer risk being the middleman. However, we will work with you to obtain any required pre-authorizations and 'more visit' requests and will quickly help troubleshoot any questions or concerns you bring to us.

Keep in mind that even after paying your "estimated" amount each visit, there may be a balance due at the end of your program- we may owe you or you may owe us. This situation is PREFERRED over getting a large bill at the end.

Note: if the information provided by your insurance company is not accurate, or your coverage changes, you will need to help us get paid by your insurance company. If they don't pay us, you will be fully responsible for the bill.

_____ (Patient Initials)

## Insurance Coverage Details (required from patient before 1st visit)

1. What is my calendar year deductible for physical therapy? $_____
2. How much of it has been applied to my deductible to date? $_____
3. What is my out of pocket maximum? $_____
4. How much of it has been applied to date? $_____
5. What percentage of my physical therapy visits will you cover? _____%
6. What is my physical therapy co-insurance (%) or copay ($) responsibility per visit?

_____

7. How many visits do I get per calendar year? _____
8. How many visits have I used to date? _____
9. Do I require a pre-authorization? Y or N, Authorization Phone #:_____
10. What is my allowed maximum per calendar year? _____
11. Can additional visits be requested after the calendar year maximum has been met? Y or N
12. Is a Physician prescription (MD signature) required? Y or N
13. Are my visits allowed per calendar year combined with OT, Chiro, Speech, or Acupuncture? Y or N
14. Who am I speaking with? _____
15. What is the reference # for this call? _____
16. Date of this call:_____

I have provided the above benefit information, which is accurate to the best of my knowledge. I understand that Physical Therapy Solutions will use this information to determine what to collect from me and bill my insurance during the course of my care. I have been made aware that Physical Therapy Solutions will not re-verify what I have provided & understand that I am financially responsible for all charges in the event that my insurance company does not pay as expected.

Patient Name Printed _____

Patient Signature _____ Date:_____