PERFORMANCE PHYSICAL THERAPY

5070 W. Rawson Ave
Franklin, WI 53132
414-377-9765
Fax 414-377-9769
www.ksrpt.com

Financial Policy

Thank you for choosing KSR Performance Physical Therapy for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of our fees.

Insurance Patients (Medicare, WEA, BCBS of Wisconsin & Humana):
All co-payments are due at time of service. I acknowledge that in consideration of the services provided to me by KSR Performance Physical Therapy, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide KSR Performance PT with my current insurance information and to familiarize myself with my insurance plan and it's policies. Any questions with my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that all or a portion of the charges and balance will remain my personal responsibility, such as deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible. I agree to pay any such amounts which are my responsibility.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize KSR Performance Physical Therapy to furnish information to my insurance carrier(s) concerning this treatment and I hereby assign all payment for services rendered to KSR Performance Physical Therapy. _____(Initial)

Medicare Patients:
Have you had any PT this year provided in your home or another outpatient clinic? □Yes □ No _____ # of visits

Self-pay Patients (Out-of-Network Policy):
For patients without insurance or with insurance that we are not contracted with, we offer self-pay rates which must be paid at time of service and we will not bill your insurance company.
We can, upon request, provide receipts with diagnosis and treatment codes which you may submit to your private insurance company for out-of-network benefits (if applicable)
We accept cash, personal checks, & credit cards. _____(Initial)
Please note that refusal to sign this form does not change responsibility for payment in any way.

I have read and understand the financial policy of KSR Performance Physical Therapy. By my signature below, I consent to the above terms and conditions of treatment and understand that it is my responsibility for assuring that the financial obligation of my care is fulfilled.

_____
Printed Name (Patient or Guardian)

_____ _____
Signature Date