Bull City Physical Therapy
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COURTESY INSURANCE VERIFICATION

Important Information Regarding Your Insurance Benefits

As part of our commitment to transparent communication, we want to provide you with essential information about your insurance benefits for physical therapy services. Understanding your coverage can help ensure a smoother experience during your treatment.

Insurance Verification Process:

Our team has taken the initiative to verify your insurance coverage by contacting your insurance company and checking online portals for current information on your eligibility and physical therapy benefits. We document details from the call, including coverage information, representative name, and a reference number. It's important to note that insurance disclaimers state the provided information is not a guarantee of coverage and may change, even retroactively.

Important Patient Disclaimer:

This notice is not a guarantee of payment. Benefits are subject to contract limits and member status on the date of service. Accumulated amounts, like the deductible, may change as additional claims are processed. Coverage is determined based on existing facts when services are rendered, subject to plan provisions, including eligibility, exclusions, limitations, and state mandates. Coverage is determined by the plan at the time of claim review. It is recommended to review your insurance plan documents or contact your insurance provider directly for the most accurate and up-to-date information on your coverage.

Patient Agreement Statement:

I,_____, acknowledge and understand the insurance information provided by ***Bull City Physical Therapy***. The clinic has verified my insurance coverage, maintaining detailed records of the process and providing me with relevant information. I understand this is not a guarantee of payment, with benefits subject to contract limits and member status on the date of service. I am aware that coverage details may change, and it is recommended to review my insurance plan documents for the most accurate information.

By signing below, I confirm that I have read and understood the information provided, and I agree to the terms outlined in this patient agreement statement.

Signature: _____ **Date**: _____

Printed Name: _____

Relationship to Patient: _____