



INSURANCE VERIFICATION SUMMARY, DISCLAIMER & CANCELLATION POLICY

Welcome to Rapha Physical Therapy, Inc. _____! We have attained insurance benefit information on your behalf. This does not represent a guarantee of payment. Please contact the member services department of your insurance provider regarding any questions or concerns about benefits or unpaid claims. All claims must be received and reviewed by your insurance company before any payment determination can be assessed. Any treatment that is uncovered and/or unpaid by your insurance is patient or, in the case of minor, the guarantor's responsibility.

The insurance you have provided for us is: _____

1. Type of provider we are: IN NETWORK OUT of NETWORK
2. **Co-Pay:** \$_____ is your co-pay per visit. Co-pays are due prior to each visit.
3. **Co-insurance:** Your insurance company will cover _____% of the allowed amount. Your responsibility is _____%. An estimate of \$_____ will be due from you prior to each visit. This amount will be applied toward the patient's responsibility as allocated by your insurance company. (Your coinsurance benefits will not commence until you have met your deductible for the year. If you have not met your deductible for the year, we will collect a larger amount until the deductible is met. See below)
4. **Deductible:** \$_____ is your deductible per calendar year. Your insurance stated you still owe \$_____. Please make \$_____ payments each visit towards your deductible until it has been met. Your coinsurance will be collected and/or billed to you after your deductible has been met.
5. You have a visit limitation of _____ per calendar year per diagnosis
6. Pre-authorization or certification is required not required
7. If pre-authorization is required, the amount you have authorized is _____.
Contact was _____ Phone _____ Auth# _____
8. Physical Therapy benefits are combined with the following _____.
9. Medicare only: Supplemental secondary insurance covers 20% of Medicare allowable charges.

CANCELLATION AND NO SHOW POLICY: Rapha Physical Therapy, Inc. reserves the right to charge any patient (or their guarantor) **a late cancellation fee of \$50.00** if a cancellation is not made at least 24 hours prior to their scheduled appointment. This fee is not covered by any insurance plans, including worker's compensation. The late cancellation or no show fee will become the patient's (or their guarantor's) immediate responsibility.

Your signature below indicates you have read and understand your insurance verification summary, insurance disclaimer and the facility cancellation policy.

Patient or Guarantor's Signature

Rapha PT staff