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1515 Kensington Ave
Buffalo, NY 14215
Ph: 716-440-1118

Fax: 888-401-2425

familycarept@yahoo.com

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Family Care Physical Therapy (FCPT)

Patient Insurance Waiver

I, _____, understand that I am responsible for payment-in-full of any charges related to my care at Family Care Physical Therapy. I authorize FCPT to submit these bills to my insurance carrier.

If I wish FCPT to submit these bills to my insurance carrier, I will be responsible for providing all necessary insurance information including referrals when required for payment. I will be responsible for paying co-payments if required on the day of service.

I authorize FCPT to receive payment directly from my insurance company.

If my insurance carrier denies payment for any reason, I agree to pay for these services in full.

I also agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorneys fees and court costs incurred in such collection efforts. I also agree to pay a $20 fee on all returned checks.

Patient Acknowledgement of Receipt of

Notice of Privacy Practices

I acknowledge that I have received a written copy of Family Care Physical Therapy's Notice of Privacy Practices effective February 1, 2008.

Today's Date: _____

Date of Birth: _____

Signature of Patient or Personal Representative: _____