**New York Physical Medicine Center**

**Statement of Patient Financial Responsibility**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The New York Physical Medicine Center, LLC appreciates the confidence you have shown in

choosing us to provide for your health care needs. The services you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

**Co-Pay Policy**

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

**Cancellation/No-Show Policy**

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours prior to your appointment to cancel. I understand if I no-show for two consecutive appointments, or cancel a total of four consecutive appointments, I may be discharged from care. The office will notify you and/or your lawyer in writing, via certified mail, if you are discharged from care.

**Self-Pay**

I do not have health insurance and will be responsible for services rendered here at **New York Physical Medicine Center, LLC**. I agree to pay **New York Physical Medicine Center, LLC,** the full and entire amount of treatment given to me or the above named patient at each visit.

I have read the above policy regarding my financial responsibility to **New York Physical**

**Medicine Center, LLC,** for providing rehabilitative services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to **New York Physical Medicine Center, LLC**, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_