ACKNOWLEDGMENT OF SELF-PAY STATUS PATIENT RESPONSIBILITY

Body Logic Physical Therapy cash pay rates are as follows:

- $150.00 per initial evaluation (1 hour in length)
- $100.00 per follow up (30 minutes in length)

This letter of acknowledgement is provided to you because you have elected to pay for the service in full on the date of service and will not be submitting a claim to an insurance carrier. You have requested a "self-pay" coded service because (initial one):

_____ You have no health insurance.

_____ We do not take your health insurance, cannot bill it, and you will pay out of pocket.

_____ You have health insurance but do not want to bill and instead want to pay out of pocket.

_____ Treatment reason is related to an auto accident/injury.

_____ Other (please explain): _____

By signing below you agree to:

- All fees for the self-pay service must be paid on the date of service.
- If you have insurance or other types of coverage, services received today that are coded with "self-pay" will not likely be reimbursed by your carrier or applied to your deductible.

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions.

I confirm that I am the patient, or the patient's duly authorized representative.

Date:

_____

Patient or Representative Signature

Date:

_____

If signed by someone other than the patient, specify relationship to patient: