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**Coastal Physical Therapy Services, LLC**

**PATIENT INSURANCE AGREEMENT**

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The following information was obtained from your insurance company by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_on\_\_\_\_\_\_\_\_\_\_\_\_\_\_. (EMPLOYEE NAME) (DATE)

|  |  |
| --- | --- |
| Primary Insurance Name |  |
| Policy Holder |  |
| Policy Number |  |
| Effective Date |  |
| Secondary Insurance Name |  |
| Policy Holder |  |
| Policy Number |  |

* **Plan requires deductible/coinsurance**

Individual deductible: $\_\_\_\_\_\_\_\_\_\_\_\_

Once deductible is met, patient is responsible for \_\_\_\_\_\_\_\_ % of bill until $ \_\_\_\_\_\_\_\_ out of pocket max (OPM) is satisfied.

$ \_\_\_\_\_\_\_ of deductible met at time of call

$ \_\_\_\_\_\_\_ of OPM met at time of call

* **Plan requires copay**

Patient Copay: $ \_\_\_\_\_\_\_\_\_\_\_\_ /visit

Copay Max: $ \_\_\_\_\_\_\_\_

Amount met at time of call $ \_\_\_\_\_\_\_\_

Evaluation copay $ \_\_\_\_\_\_\_\_\_

Re-evaluation copay $ \_\_\_\_\_\_\_\_

Plan has a visit limit of \_\_\_\_\_\_\_\_/ year.

 # Visits used at time of call \_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Patient would like to abstain from billing insurance and receive treatment at the self pay rate of $150/evaluation and $75/visit thereafter.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby agree to pay $ \_\_\_\_\_\_at the time of service.

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan requires authorization:

* Yes, at \_\_\_\_\_\_\_ visit
* No

Plan requires referral:

* Yes
* No