Cura Centers

Patient Name: _____ Date:____/____/_____

BENEFITS ACKNOWLEDGEMENT

Canton Physical Therapy Centers will no longer be informing patients of their insurance benefits. There have been many changes in insurance and the benefit printouts we receive are not always accurate and up to date. Please look on the back of your card and call the number or go online to check your benefits for physical therapy. Depending on your plan, there may be a deductible, a co-pay, or a co-insurance. There may also be a limit on the number of visits per year your insurance plan allows. If you do have a limited number of visits be sure to know if those visits apply to Calendar year or Plan year. Please know your benefits because when claims are processed at your insurance they go by the benefits you have at the date of the service. We are not responsible to inform you ahead of time if there are any limits as to the number of visits your insurance allows.

Some insurances require Canton Physical Therapy Centers to get authorization before they will apply the service towards the patient's benefits for payment. This means that the insurance will approve or deny your doctors request based on whether they feel it is medically necessary. Authorization is done by a separate company which your insurance hires to run the authorizations. If you get authorized visits it means that the insurance feels that it is medically necessary for you to receive treatment on that day. The bill is then sent to your insurance and at that point they will see if the patient has the benefits for that claim to be paid.

By signing below, I understand that I am responsible to know what my insurance benefits for physical therapy. I understand I may have a deductible, copay, and co-insurance and if it is not collected at the time of service I will be billed. I understand that there may be a limit on the total number of visits my insurance will allow each year and if I go over that amount I will be responsible for the entire charge for that date of service. I understand that authorized visits are different than my total yearly benefits and the insurance may authorize visits that may not be paid because benefits have been exhausted.

Have you had physical therapy this year? Yes _____ No _____

By signing this I agree that I will find out and keep track of my physical therapy benefits and I understand all the above.

Signature of patient or guardian: _____ Date: ____/____/_____

NON-COVERED TREATMENTS - NOT ALL TREATMENTS ARE COVERED BY YOUR INSURANCE PLAN

Treatments such as **IONTOPHORESIS** and **TAPING** may be used by your therapist but are **NOT COVERED** by your insurance. Some insurance plans cover the cost of these treatments. If you have any questions concerning this or any other part of your treatment, please ask your therapist or contact our billing department. Fees for these treatments will be collected at the time of service or billed to you after the claim has processed at your insurance. **Iontophoresis:** $15.00 each visit it is used, **Taping:** there is a $3 charge per visit it is used.

Signature of patient or guardian: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Signature of patient or guardian: _____ Date: _____

Print Name: _____

If not signed by the patient, please indicate your relationship to the patient: _____

***Below Line For Office Use Only*:**

Signed form received by: _____
Acknowledgment refused:
Effort to obtain:_____

Reason for refusal:_____

Rachel Devlin, Privacy Officer (860)-693-6226