

PAYMENT AGREEMENT FOR PATIENTS WITH NO INSURANCE

The patient is responsible for:

- payment of all visits in full
- payment for all durable medical equipment

I hereby recognize that the costs of physical therapy services rendered to me are my responsibility. I agree to pay for services on the day of my physical therapy visit.

Signature of patient

Date

If a parent or guardian is responsible for payment of services for the patient, they must fill out and sign this form:

Patient name _____

Parent/Guardian Name _____

Address _____ Personal phone _____

Place of Employment _____ Work phone _____

Social Security # _____

I hereby recognize that the costs of physical therapy services rendered to _____ are my responsibility. I agree to pay for (patient) services on the day of his/her physical therapy visit.

Signature of parent/guardian

Date