FORCE
PHYSICAL THERAPY

Phone: 305.935.9599
Fax: 305.932.5612
forcetherapy@gmail.com
www.forcesportstherapy.com

Copayment/Coinsurance Promissory Agreement

Dear Patient:

Your insurance company requires a Copayment/ Coinsurance to be paid when you seek certain medical services. In turn, we are contractually obligated to collect any deductible, copayment, or coinsurance from our patients.

I, _____, acknowledge that my insurance company and I have an agreement and I am responsible for the payment of any copayment, coinsurance, or deductible for health services provided to me, or my dependent.

I promise and attest that I will pay the required deductible, copayment, or coinsurance to Force Physical Therapy within thirty (30) business days from receiving a bill. Patient statements are mailed when explanation of benefits are received from your insurance company.

I understand failure to make payment, or to arrange payment that satisfies our financial policies, in thirty (30) business days may result in health insurance notification and an additional $30.00 administrative fee to be added to the original amount due.

Patient Authorization:

By my signature below, I also hereby authorize assignment of financial benefits directly to Force Physical Therapy for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment.

Signature _____ **Date** _____

Patient's name if different than signer: _____