Life Strength Physical Therapy, Inc.
110 West Road, Suite 105
Towson, MD 21204
Phone 410-321-4901
Fax 410-321-4903

PAYMENT RESPONSIBILITY WAIVER

PATIENT NAME: _____

PATIENT ADDRESS: _____

_____

(Please circle the number of the appropriate option.)

1. I understand that the provider of services DOES participate with my insurance. If for some reason my insurance denies payment, I accept the responsibility for payment of charges for services.

   I also acknowledge that I am responsible for payment at the time of service of any copay or coinsurance required by my insurance.

2. I understand that the provider of services DOES NOT currently participate with my insurance carrier. I accept responsibility for payment of all charges at the time of service.

3. I wish to pay for services out of pocket and to NOT have these charges submitted to my insurance carrier.

In signing this, I also acknowledge that I am responsible for notifying LifeStrength Physical Therapy of any changes in my insurance coverage.

_____ DATE: _____

PATIENT/GUARANTOR SIGNATURE