



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 of any copay required by my insurance at the time of service.
  
2. I understand that the provider of services DOES NOT currently participate with my insurance carrier. Further, I understand that the provider will submit my claim for today and any future visits. I accept responsibility for payment of any charges not covered by my insurance.
  
3. I wish to pay for services out of pocket and to NOT have these charges submitted to my insurance carrier.

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

\_\_\_\_\_

DATE: \_\_\_\_\_

PATIENT/GUARANTOR SIGNATURE