



# EXPLANATION OF INSURANCE BENEFITS

\_\_\_\_\_  
Patient Name

Our records show that your primary insurance policy is with \_\_\_\_\_. For your convenience, we have called to inquire about your physical therapy benefits. For your specific policy, reimbursement for physical therapy services is paid at \_\_\_\_\_ % of the allowed amount. The remaining \_\_\_\_\_ % is the patient's responsibility. Your deductible is \$\_\_\_\_\_ and \$\_\_\_\_\_ has been met year to date. Your co-pay for each physical therapy visit is \$\_\_\_\_\_.

Other information given is as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have a secondary insurance we will bill one second or supplemental insurance as a courtesy. Please be aware that payment may be denied for services, as we are not contracted with all secondary insurances. If you do not have a secondary or supplemental policy, payment is due after Medicare has processed your claim. Any amounts not covered by a second or supplemental policy will become the patient's responsibility.

Have you had any type of physical therapy within the last year?	Yes	No
Have you had any services this year by any Home Health Agency?	Yes	No

I understand and agree to the above information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date