600 Pine Avenue
Niagara Falls, NY 14301
Phone: 716-282-6765 * Fax: 716-282-6725

3620 Harlem Rd, Ste 2
Cheektowaga, NY 14215
Phone: 716-446-9500 * Fax: 716-446-9501

Notice of Financial Responsibility

_____ **(Patient Name)**

_____ **(Insurance Company)**

_____ **(Social Security Number)**

_____ **(Insurance ID Number)**

_____ **(Date of Birth)**

_____ **I am receiving Home Health Care Services**
_____ **I am NOT receiving Home Health Care Services at this time**

**** I will advise Glover Physical Therapy, PLLC of any change in the above information****

BILLING AGREEMENT

As a courtesy, Glover Physical Therapy and Pain Rehabilitation agrees to bill the above Insurance Company on my behalf. Glover Physical Therapy, PLLC will assist in obtaining information regarding co-pays/coverage limits/authorizations/referrals, etc. However I fully understand it is ultimately my responsibility to know my insurance plan.

Furthermore, I understand that I am financially responsible for all physical therapy charges incurred. Should my insurance carrier ever deny payment for treatment received, or retract payment made on services rendered, I personally will reimburse Glover Physical Therapy, PLLC for such services. Additionally, I understand that I am financially responsible for any collection/attorney fees that may be assessed to my account due to non-payment of these charges.

Glover Physical Therapy and Pain Rehabilitation will do its best to accommodate you, the patient by entering into a re-payment agreement if necessary.

Signature Date