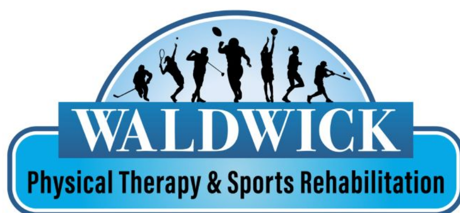

Waldwick Physical Therapy and Sports Rehabilitation (WPT)

Patient Financial Responsibility Form

______ I ______________________________ have been made
Initials aware that Waldwick Physical Therapy and Sports Rehabilitation is an **OUT-OF-NETWORK PROVIDER**

_______ I understand that I will be financially responsible for
Initials $____________ ***for the initial evaluation***

$____________ ***for each follow-up visit***
for physical therapy services provided.

_______ I understand that I may receive an **Explanation of**
Initials **Benefits** (EOB) with or without **checks** from my insurance company for services provided.

_______ I understand that I must bring all **CHECKS and EOBs**
Initials **to WPT.** I agree to endorse any checks received from my insurance company and turn them all over to GRPT as payment for services rendered. I understand that I will not receive an itemized invoice from GRPT but I can request copies of all insurance documents for services rendered.

_______ **WPT** reserves the right to collect on balances due.
Initials

I agree to the terms outlined above.

____
Patient Signature

____
Witness/GRPT