PATIENT RESPONSIBILITY FORM

Name: _____

It is understood that I am responsible at each visit for my copayment and/or any unpaid or denied dates of services. I also understand how many visits my insurance company allows each year, per condition, per lifetime, per authorization and, if I go over this amount, I will be responsible for payment of these visits. If my policy has a deductible, it is my responsibility to see that these costs are paid in full.

NF PATIENTS: any denials per your carrier due to IMEs will be your responsibility

I also understand that when I fail to show for a scheduled appointment, without prior notification, the first time is a warning. Any time after that will result in a $10 fee per missed visit.

I hereby assign to Babylon Physical Therapy all payments for medical services rendered to me, or my dependents, and that I am responsible for any amount not covered by my insurance.

Signature: _____ Date: _____