INSURANCE BENEFIT ACKNOWLEDGEMENT FORM

PATIENT NAME: _____

INSURANCE: _____

ANNUAL DEDUCTIBLE: _____
(PATIENT RESPONSIBILITY)

BENEFITS: _____
(WHAT THE INS. WILL PAY ONCE DEDUCTIBLE HAS BEEN MET)

PATIENT RESPONSIBILITY: _____
(AFTER DEDUCTIBLE IS MET)

LIMITATIONS: _____ / _____
(HOW MUCH THERAPY YOUR INS. WILL ALLOW) / (HOW MANY VISITS HAVE BEEN USED)

REFERRAL NEEDED : YES or NO **COPAY: YES or NO** **AMOUNT: _____**

** This Quote is not a Guarantee of payment. Benefits, if any, will be assessed by your insurance plan carrier upon receipt of claims and are subject to eligibility and based on plan provisions and limitations in effect at the time services are rendered. **By signing below you acknowledge that you understand this disclaimer and agree to pay any and all patient responsibility as determined by your insurance plan carrier.**

X _____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE