SUBMIT FORM

Billing & Insurance Policy

At **Flow Physical Therapy**, we strive to provide transparent and flexible payment options for our patients. Please review and acknowledge the following financial policies:

Patient Information

Patient Name: _____
Date of Birth: _____

1. Insurance Billing

☑ **We can submit claims to your insurance provider** if we are in-network.
☑ **Verification of benefits is not a guarantee of coverage**, and you are responsible for any portion not covered by your insurance, including deductibles, co-pays, and co-insurance.
☑ **If Flow Physical Therapy is out-of-network**, you may be responsible for a larger portion or the full cost of services.
☑ **It is your responsibility** to check with your insurance provider regarding coverage for physical therapy services.

2. Self-Pay / Cash Rates

For patients who prefer to **pay out-of-pocket**, the following cash rates apply:

Initial Evaluation: $150
Follow-Up Visit: $125

◯ **I elect to self-pay for my physical therapy services at the rates listed above.**

◯ **I elect to have Flow Physical Therapy bill my insurance provider and understand that I am responsible for any remaining balance.**

Late Cancellation & No-Show Policy

To provide quality care and accommodate all patients, we require at least **24 hours' notice** for appointment cancellations or reschedules.

A $50 fee will be charged for cancellations made **less than 24 hours before a scheduled appointment** or for **missed/no-show appointments.**

By signing below, I acknowledge and agree to the **late cancellation/no-show fee** policy.

Financial Responsibility Agreement

By signing below, I acknowledge that:

- **I am financially responsible** for all services received at Flow Physical Therapy, including any amounts not covered by my insurance.
- **I understand my payment options** and agree to pay for services at the time of my visit if I am self-paying.
- **I am aware of the $50 late cancellation/no-show fee** and agree to pay it if I cancel within 24 hours or miss an appointment.
- **I will notify Flow Physical Therapy** immediately if there are any changes to my insurance coverage.
- **I understand that unpaid balances may result in additional fees**, and past-due accounts may be sent to collections.

Payment Authorization & Signature

By signing below, I confirm that I have read and understand the **Financial Responsibility & Payment Agreement**, and I agree to the terms outlined above.

Patient Signature: _____
Date: _____

Parent/Guardian Signature (if applicable): _____
Date: _____