372 West Lancaster Ave
Wayne, PA 19087

Patient Financial Responsibility Form/Self-Pay Waiver

Thank you for choosing **IM | Health** for your medical needs. We are committed to providing you the highest quality healthcare, but we are not a collection agency.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment of treatment and care.

Please select ONE below:

☐ You agree to the **self-pay rate (initial PT evaluation - $135.00; follow-up PT visit - $115.00) for services rendered, at time of service.**

* ***IM | Health Physical Medicine*** *department is currently* ***NOT*** *in-network with any Keystone Health Plan East or Cigna health insurance plans. If you chose to proceed in scheduling Physical Therapy with* ***IM | Health****, please check off the above option.*

☐ You elect to use available medical insurance for visit coverage.

- We will bill your insurance for you, however the patient is required to provide the most correct and updated information regarding insurance.
- Copayments are due at the time of service.
- Patients are responsible for payment of copays, co-insurance, deductibles, and all other procedures or treatment not covered by their insurance plan.
    - You will NOT receive a bill. Your credit card on file will be charged, and a receipt published to your patient portal.

WE ARE NOT A COLLECTION SERVICE.
You will be charged for any balance your insurance contract designates as your responsibility.

*Please note when choosing **either** of the above options; **A VALID CREDIT CARD ON FILE WILL BE REQUIRED PRIOR TO SERVICE**

By my signature below, I hereby authorize assignment of financial benefits directly to **IM | Health** and any associated entities for services rendered as allowable under standard third party contracts. I understand that I am financially responsible for charges not covered by this assignment. **I also accept the fees charged as a legal and lawful debt and agree to pay said fees, including any/all collection agency fees, if such be necessary.** I understand that **IM | Health** does not participate with any Medicaid/QMB products and that I will be responsible for any balances resulting from my care.

Patient Name **Date of Birth**

Signature (Patient/Guardian) **Date**