Cash Payment Consent Form

Date _______ /_______/_______

Patient Name: ____

I have agreed to pay cash for physical therapy services at the time that services are rendered on date above. I understand by doing so I am deciding to opt out of the facility billing my insurance for these services. I also have agreed to a cash discount as noted on the fee schedule.

Physical Therapy Cash Fee Schedule

Initial Evaluation - $140.00

Office Visits: **1-hour**- $120.00, **30-minute**-ART focused - $72.00

Package of 5 1-hour sessions - $510 (15% Discount - $90 Savings)

Military / Senior (65+) Discount: Initial Evaluation - $105.00 **Office Visit -** $90.00

Please check the appropriate option below:

_____ I do not have health insurance.

_____ I have health insurance that is either accepted or not accepted at this facility, but I choose to pay cash and not bill my insurance for these services.

_____ I have health insurance, but it is not accepted at this facility, so I choose to bill it on my own.

Insurance Company Name ____________________________________

Sign x____________________________________ Date: ______/ _______/ ________

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