



**P R E M I E R**  
**PHYSICAL THERAPY**

*Where it's all about you... all the time.*

**NOTIFICATION OF PATIENT RESPONSIBILITY FOR  
CO-PAYMENTS AND DEDUCTIBLES**

Your insurance policy requires the payment of co-payments and deductible amounts from you at the time of service. Your insurance company also requires Premier to collect your co-payment or unmet deductible amount or we could be in violation of our contract with your insurance company and risk not being reimbursed for your treatment process.

Premier Physical Therapy has verified your insurance coverage and based on information provided to us by your insurance company, the estimated amount you are responsible for is:

**COPAYMENT AMOUNT** \_\_\_\_\_/per visit

**DEDUCTIBLE AMOUNT** \_\_\_\_\_

Please verify that you understand your financial responsibility as previously stated by signing below.

\_\_\_\_\_  
**Patient Signature** **Date**

\_\_\_\_\_  
**Printed Name** **Date**

\_\_\_\_\_  
**Premier Representative** **Date**



We are required to collect the above co-payment amount for each treatment session. If weekly or monthly payments are necessary, Premier will be happy to arrange an individual payment schedule to best suit your needs. By signing this document, you will be responsible for the agreed terms of this plan unless otherwise noted. We accept payment by Visa, Mastercard, American Express, check or cash. As a courtesy, Premier will bill your insurance company for their portion of payment.

**Payment Plan** \_\_\_\_\_

**Patient Signature** \_\_\_\_\_

**Premier Representative** \_\_\_\_\_