HolistiCare
Physical Therapy, LLC

Advanced Beneficiary Notice

Please take the time to read the following information carefully:

Thank you for selecting **HolistiCare Physical Therapy** for your rehabilitation. We look forward to providing you exceptional service for your needs!

By electing to participate with **HolistiCare Physical Therapy**, you are accepting financial responsibility for the services that will be rendered. We would like to take this opportunity to explain to you know how our billing and insurance reimbursement services function.

At **HolistiCare Physical Therapy**, we will bill any insurance company as a courtesy to you, but it is your responsibility to contact your provider, if you need clarification on your benefits for outpatient physical therapy.

Most insurance providers require a written prescription from a medical provider (MD, DO, DPM & etc) in order for physical therapy services to be reimbursed. These insurance plans also place a “cap” on outpatient rehabilitative services. This means that they will only pay a set amount per visit or a set number of visits within a calendar year. Any balance above and beyond the insurance coverage, will be your responsibility. Deductibles and copayments/ coinsurance may also apply depending on your insurance.

I, _____, accept financial responsibility for services I receive at **HolistiCare Physical Therapy**, which are not covered by my insurance. I agree to pay any balance owed after insurance reimbursement, and in signing, I have been notified by **HolistiCare Physical Therapy** of such policies.

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Signature Date