

Physical Therapy of Colleyville

Date: _____

Patient: _____

Account: _____

Insurance ID#: _____

Provider: _____

Patient's health insurance carrier is _____,
Physical Therapy of Colleyville is not in this carrier's network.
Accordingly, treatment by Physical Therapy of Colleyville or
Its employees or agents will be considered to be rendered
Out of Network.

Patient acknowledges that he/she has been advised that the
Applicable in-network co-payment amount is \$_____.
Patient has been advised the applicable in-network deductible
is \$_____.
Out of Network benefits are _____
_____.

Patient acknowledges that therapy services often involve
Frequent encounters and as a result, payment of the full
Amount set forth as out of network benefits would result in a
Financial burden which may impede Patient's access to
Legitimate and necessary therapy services. As a Result,
Physical Therapy of Colleyville agrees to waive some or
All of the above out of network coinsurance amounts. Patient
Agrees to be responsible for the amount of \$_____.

_____.
This is consistent with Physical Therapy of Colleyville's
Policies regarding the payment of patient balances.

Patient signature

Employee of Physical Therapy of Colleyville signature