ESPT
Elite Sports Physical Therapy

Advanced Beneficiary Notice

Please take the time to read the following information carefully:

Thank you for selecting to pursue your rehabilitation and treatment at **Elite Sports Physical Therapy (ESPT)**. We seek to be the premier orthopedic and sports physical therapy clinic in Fremont. Our goal is to provide you care that not only meets, but *exceeds* your expectations, and helps improve your quality of life.

By electing to participate in physical therapy from ESPT, you are accepting financial responsibility for the services that we will provide. This responsibility obligates you to ensure payment in full of your fees. As part of our program, we would like to take this opportunity to let you know how our billing and insurance reimbursement services function.

At ESPT, 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 (physician, chiropractor, osteopath) 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 co-payments/coinsurance may also apply depending on your insurance. **Co-payments are due at the time of service.**

I, _____, accept financial responsibility for services that I receive at **Elite Sports 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 **Elite Sports Physical Therapy** of such policies.

_____ _____
Signature Date

_____
Relationship To Patient