

**LONG ISLAND UNIVERSITY CENTER FOR PHYSICAL REHABILITATION
REIMBURSEMENT INFORMATION & POLICY**

Patient Name _____

Payor (if not the patient) _____

Long Island University Center for Physical Rehabilitation will bill your insurance carrier for all physical therapy services provided. It is understood that the patient, or payor, is responsible for your yearly deductible amount, any percentage stipulated by your particular plan, and any balance not covered by your insurance carrier. For example, if the insurance carrier covers 80% of our fee, the patient or payor will be responsible for the remaining 20% at the time of the visit. If the insurance carrier denies payment, the patient or payor will be responsible for those fees.

Please note: If your insurance carrier terminates your coverage while you are undergoing treatment at LIUCPR, you are responsible for any and all unpaid charges.

Initials _____

IF WE ARE PARTICIPATING PROVIDERS IN YOUR HEALTH PLAN...

then you, the patient, is responsible for the co-payment fee outlined by your specific plan. If you are unsure of the specifics of your plan, please contact a representative at the carrier company or ask our Office Manager.

If you don't know if we are a participating provider in your particular plan, please ask!

Initials _____

I, _____, hereby authorize Long Island University Center for Physical Rehabilitation to release my protected health information acquired in the course of my evaluation and treatment in order to accurately and efficiently process my insurance claims. I have read and understand the information in this Reimbursement Information and Policy form. I attest that all information provided by me is true to the best of my knowledge.

Patient Signature _____ Date _____

Payor Signature (if not the patient) _____ Date _____

Print Name of Payor (if not the patient) _____