PROMPT/SELF PAY FORM

Patient Name: _____ DOB:_____

Street Mailing Address: _____

City_____ State _____ Zip Code_____

Home Phone: (_____) _____Work/Cell Phone: (_____) _____

I agree to pay the prompt/self rate of:

Eval and re-eval rate:

Therapy visit rate:

BY COMPLETING THIS FORM, I UNDERSTAND THAT:

- I am required to pay, in-full the prompt/self pay rate as stated above, at time of service. If full payment is not made at time of service, my insurance may be billed without notice and I may be billed for any unpaid charges. Any charges not paid at time of visit must be paid within thirty (30) days of my service. If I have not provided insurance and I do not pay at time of service, then I understand I will be billed for full gross charge due in full thirty (30) days from the date of service.
- During future visits to **Pacific Rehabilitation & Sports Therapy**, providers may reference this visit in their notes and those documents may be sent to my insurance provider to justify payment for those future visits. **Pacific Rehabilitation & Sports Therapy** will not redact or alter those notes.

SIGNATURE

_____ _____ _____

Signature of patient or legal representative | Date | Relationship to Patient

_____

Printed name of patient

_____

Printed name of legal representative (if applicable)

FOR INTERNAL USE ONLY

Date Received: _____

Date Payment Received: _____

Staff Signature: _____ Staff Name: _____

©PRNPT-719