Please Read and Sign

Dear Patient:

Tranquillity Physical Therapy will bill your insurance company **as a courtesy**.

Please be advised that this is a brief summary. The benefits outlined are given as quoted by an insurance representative. **THIS IS NOT A GUARANTEE OF PAYMENT BY THE INSURANCE COMPANY.**

Tranquillity Physical Therapy Services, Inc. will carry your account for 60 days. If your insurance company has not acknowledged any portion of your account within 60 days, the balance is due and payable in full. You will be responsible for the entire debt incurred for services rendered at Tranquillity Physical Therapy. Accounts remaining open after sixty (60) days are subject to be turned over to collection.

Tranquillity Physical Therapy reserves the right to charge the patient a cancellation fee of $25.00 if the cancellation is not made within twenty-four (24) hours of the scheduled appointment. (Note: Cancellation fees are not covered by the insurance plans).

This agreement is binding regardless of any legal transactions currently in progress or initiated during the course of physical therapy treatments, unless agree upon in writing by Tranquillity Physical Therapy.

Primary Insurance		**Secondary Insurance**	
Insurance Co.	________________________	Insurance Co.	________________________
Insured	________________________	Insured	________________________
Deductible	__________Met_________	Deductible	_________Met__________
Benefits	________________________	Benefits	________________________
Limitations	________________________	Limitations	________________________
	________________________		________________________

I ____________________________________, have read and do fully understand the above information provided for me and hereby agree to comply as outlined.

Signature______________________________	**Date Signed**______________________________