
# Financial Obligation Form

**AB Neuromuscular Physiotherapy, LLC** is an out-of-network licensed healthcare provider. It is the patient's responsibility to find out if they have out-of-network benefits and if they will be reimbursed for services rendered. If you provide us with your insurance information, we can submit claims on your behalf. We will submit these claims as a courtesy, free of charge. However, we are not responsible for the reimbursement amount and we have no control over the timing of any reimbursements.

Appointment Information

- Therapy sessions are one hour in length.
- Please arrive promptly for each scheduled appointment. Arriving later than 10 minutes into a scheduled appointment may prevent you from receiving the full time of the treatment session.
- At AB Neuromuscular Physiotherapy LLC, we understand that sometimes a patient must cancel an appointment. In that event, you must cancel by 5:00pm, one day before your scheduled appointment. We reserve the right to charge for time reserved without proper cancellation. The cancellation fee is $265.
- If you miss more than two appointments without prior notification, we reserve the right to charge you the full session amount and cancel all subsequent visits.
- We accept payment in the form of cash, check or credit card.

I understand and agree that I am financially responsible for full payment of my bill of services at the time of service.
_____ Initial

I understand the cost of therapy is: $495 First Initial Evaluation visit, $400 Follow-up visit.
_____ Initial

I understand that if paying with a credit card, I will be charged an additional $10 service fee.
_____ Initial

I understand that **AB Neuromuscular Physiotherapy, LLC** may submit insurance claims on my behalf to my insurance company or can provide an itemized invoice with all the information that I can use to file for reimbursement with my insurance company.
_____ Initial

I understand the **AB Neuromuscular Physiotherapy, LLC** financial policy and take financial responsibility for my account. This AGREEMENT is executed by me as of the ___ day of _____, 20___.

_____ _____
Patient Name (please print) Signature of Parent or Guardian (If applicable)

_____ _____
Patient Signature Witness Signature