J.Z. MANN PEDIATRIC THERAPY

410 New Bridge Street Suite 10-A
Jacksonville, NC 28540
Phone: 910-347-2212
Fax: 910-347-6003 OR 910-338-5013
www.jzmannpediatrictherapy.com
Email: therapist@jzmannpediatrictherapy.com

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name: _____ DOB: _____

J.Z. Mann, Pediatric Therapy appreciates the confidence you have shown in choosing us to provide for your therapy health care needs. The therapy you have asked us to provide implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your insurance coverage, if any, and bill your insurance carrier on your behalf. **However, you are ultimately responsible for payment of your bill.**

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your insurance company. We expect you to make these payments at the time of the appointment. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you elect to continue past your approved period, you will be responsible for your balance in full.

CO-PAY POLICY

Some health insurance carriers require the patient to pay a co-pay for each appointment. It is expected and appreciated for the payment on behalf of the patient to be made at EACH VISIT. Thank you for your cooperation in this matter.

YOUR BILLING OPTIONS

In the event a portion of your financial responsibility is not met at the time of the appointment, J.Z. Mann, Pediatric Therapy will mail you a bill for the remaining balance. If you would prefer to have your bill **e-mailed** to you please fill out the appropriate boxes below. By providing us with your e-mail address and signing below you understand that anyone who has access to the e-mail account will be able to see your outstanding balance:

- ❑ Please e-mail my bill to the following e-mail address: _____

If you do not want to receive a statement in the mail **IN ADDITION TO** receiving it by email, please initial below:

_____I wish to **only** receive my bill by e-mail and understand J.Z. Mann, Pediatric Therapy is not responsible if the e-mail fails to send. If I fail to receive my bill once a month by e-mail it is my responsibility to follow up with the billing department regarding my balance.

I have read the above policy regarding my financial responsibility to J.Z. Mann, Pediatric Therapy, for providing rehabilitative services to me or the above named patient. I certify that the information provided by me is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to J.Z. Mann, Pediatric Therapy, the full and entire amount of bill incurred by me or the above named patient; or, if applicable, I agree to pay any amount due after payment and/or denial of payment has been made by my insurance carrier.

Responsible Party's Signature: _____ Date _____

Printed Name: _____ Relationship to Patient: _____

Revised 4/12/16