Physio Pro
A physical therapist owned private practice

Self-Pay Agreement

You have registered as a self-pay patient. This agreement is offered because you have indicated one of more of the following:

1. You do not have insurance in effect
2. We are not a provider within your insurance carrier's network
3. Your insurance carrier does not pay for physical therapy
4. The physical therapy maximum with your insurance carrier has been met

Further, you have indicated that it would create a financial hardship for you to pay our regular rates.

In consideration for this self-pay discount, you agree to pay the following rates for your treatment by cash, check, or credit card at the time of service.

Self-Pay Rate

Per visit - $90

You also understand and agree that we will not bill insurance for services provided under this agreement. No forms will be produced now or in the future for you or us to submit for insurance billing.

Printed Patient Name: _____

Patient Signature: _____ **Date**: _____

Witness Signature: _____ **Date**: _____

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