physical therapy
& hand centers

Patient Name (last, first)	
Patient DOB:	
Patient SSN:	

Street Address:		
City:	State:	Zip Code:

I, _____ (Patient's First & Last Name), certify that I am enrolled in a medical/health plan through a Medicare/private insurance through _____ (Insurance Carrier). I hereby agree to be a voluntary private patient of Physical Therapy & Hand Centers, Inc. As a private patient of Physical Therapy & Hand Centers, Inc, I understand the Fees for Service outlined below and I agree to pay the Fees for Service prior to services being rendered. I understand that I will not be reimbursed by my insurance carrier for any fees paid to Physical Therapy & Hand Centers, Inc. nor will any fees paid to Physical Therapy & Hand Centers, Inc. be applied to my deductible or out-of-pocket.

Fees for Services

Physical Therapy Evaluation	$200
Physical Therapy Re-Evaluation	$200
Physical Therapy Follow-Up Appointment	$200

_____

Patient Name (printed)

_____ _____

Patient Name (signature) Today's Date