Toni McGinley P.T. /ALTA PT

1845 Broadway 3RD Floor

New York, NY 10023

Patient Insurance Coverage Agreement

Date: ______________________

Dear ____ We have verified your commercial insurance and would like to make sure you fully understand your benefits. Please take a moment to review the following information:

1.) Plan Limitations:

   ________________ visits per condition per calendar year/lifetime.

   ________________ consecutive days per condition per calendar year/lifetime.

   ________________ visits based on medical necessity and subject to review.

   ________________ calendar year/contract year deductible, _____________ due.*

2.) Patient Co-payment of $_________________ per visit. We will bill your insurance carrier for your office visits. The co-payment is due either on a per visit basis or if you prefer, you may leave a credit card on file that will be billed twice monthly. Appointments not cancelled with 24 hours and missed appointments are subject to a $50.00 charge that is not billable to any insurance.

If you have any questions or concerns, please do not hesitate to contact our administrative staff at (212) 956-2900.

Thank you for your attention to this matter.

Check the box below before signing and dating below.

☐ I have read and understood this agreement. ♦ *WILL BILL $200/$150 UNTIL DEDUCTIBLE IS MET

Patient Signature: ____ Date: ____________