

**THERAPEUTIC SOLUTIONS PHYSICAL THERAPY**

1757 Merrick Avenue, Suite 100

North Merrick, NY 11566

Ph: (516) 623-4388 Fax: (516) 623-1948

**Medicare Primary / The Empire Plan Secondary Patients**

Dear Empire Patients,

In an effort for Therapeutic Solutions Physical Therapy to treat you in the most professional and cost efficient way this document serves as a reimbursement agreement between you, the patient, and Therapeutic Solutions Physical Therapy, the provider.

Therapeutic Solutions Physical Therapy is an out of network provider with your secondary Insurance The Empire Plan. According to your health plan, in an 'out of network situation', the patient is responsible for any and all deductibles as well as the co-insurance until your full deductible is met. We realize that this can be very expensive for our patients. In an effort to provide 'out of network services', at a reasonable rate for our patients, we have devised an easy payment plan. Therapeutic Solutions Physical Therapy will accept reimbursements dispensed by Empire. This is usually 50% of our fee. That is a major savings for 'out-of network services'. ***The patient will receive the payments for their physical therapy directly from The Empire Plan. It is the responsibility of the patient to bring these payments and explanation of benefits to our office, and sign reimbursements over to our office.***

The insurance company will not dispense any information pertaining to payments made by them, as we are not participating providers. It is the patient's responsibility to obtain any information in regards to payments if and when requested by Therapeutic Solutions Physical Therapy to do so. If at any time, you, the patient, is not in compliance with this agreement, you will be responsible for the full \$250.00 deductible as well as 100% of our bill.

\*\*\* This agreement is based on information obtained through your insurance company at the time we verified your coverage on your initial visit with our office. This does not guarantee payment from your insurance company. If payment is not made due to non-compliance or cancellation with your insurance you will be responsible for all visits at our reasonable and customary rate.

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Jamie Rockwin, P.T., D.P.T  
Director of Rehabilitation

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Date

\_\_\_\_\_  
Patient's name

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date