Dove Physical Therapy, LLC

Heal Under Our Wings.

www.DovePT.com

PATIENT CONSENT

SELF-PAYMENT OPTION AGREEMENT

I, _____, the patient/client, do not have health insurance coverage or opt-out of using my health insurance coverage for payment of my physical therapy services at Dove Physical Therapy, LLC (DovePT). I agree to self-pay the full fee or payment due at the time of service and will not submit/file a claim for payment of services rendered or reimbursement of my payment for services rendered. I have a clear understanding of DovePT's Financial Policy and fees as well as my responsibility. I agree that I, my caregivers, family members, authorized representatives, or power of attorney will not, under any circumstances, submit claims, invoices, receipts, statements, or treatment notes on my behalf to any primary-payer, private health insurance for reimbursement or to obtain a denial for supplemental health insurance.

I understand that I am agreeing to pay privately for the services I receive from DovePT even if those services may be covered by my health insurance plan. I understand that I will be responsible for all charges incurred from treatment(s) as a patient of DovePT, regardless of insurance coverage. I understand that signing this form is optional, and I can refuse to sign this Self-Payment Option Agreement if I decide to use my health insurance coverage.

Patient Printed Name

Patient/Guardian Signature **Date**

Please note: If patient is a minor, please have responsible party/guardian read and sign.