

Beth Shelly Physical Therapy LLC – Good Faith Estimate Self-pay

Beth’s goal

“To provide the highest quality physical therapy for pelvic dysfunction and lymphedema.”

Self-pay

At this time I am unable to process claims for several insurance companies. In addition, in some cases, out of network coverage is poor and it is actually cheaper to self-pay. I would be happy to work with you to achieve your health care goals. Several discounts are applied automatically for all patients paying for therapy on the day of service (same day payment and no billing fee). In addition, there may be additional discounts or scholarships for financial need. Please ask Beth.

- I understand Beth Shelly PT LLC will not be sending a bill to my insurance company. And that these services will not count toward my deductible.
- I understand that **I am ultimately responsible for my physical therapy charges** and agree to pay for my therapy in full at the time of service.
- I will be paying these charges by
 - ___ Cash
 - ___ Check made payable to Beth Shelly PT LLC
 - ___ Credit card, debit card or health savings accounts on line or in clinic.
- Cost of therapy varies depending on the time spent and type of treatment.
 - Initial evaluation is \$128
 - Treatment (40 to 50 min) is \$96.
 - Treatment (55 to 65 min) is \$128
- Frequency of therapy to be determined each session (often starting with once per week for three weeks and lasting 2 to 3 months).

Receipt for services can be provided at the end of your therapy for tax purposes. Please ask.

My goal is to provide high quality therapy to restore you to good health and full activity level. I look forward to working with you to achieve your health goals. Please speak to me if you have questions or concerns. 563-940-2481 An answering machine is on at all times if I am not available. A copy of this page will be provided at the time of your first visit for your future reference.

Don’t let anything get in the way of your success in physical therapy – you are worth it - achieve great health now.

Patient signature _____ Date _____