OPTCI OSTEOPRACTIC PHYSICAL THERAPY OF CENTRAL INDIANA
ORTHOPEDIC AND PELVIC HEALTH SPECIALIST

Osteopractic Physical Therapy of Central Indiana Private Payment Agreement

Osteopractic Physical Therapy of Central Indiana and its individual providers (collectively "we", "us", "our") have elected not to enroll in the Medicare Program. Stated another way, we are neither a participating provider nor a non-participating provider under the Medicare Program. Given our lack of a formal relationship with Medicare, there are limited circumstances in which we can accept direct payment from you for the services that we provide.

We believe that you are eligible to self-pay for the services to be provided by us because you have instructed us, of your own free will, to NOT submit a claim to Medicare in connection with the services. You have elected to do so with the understanding that you will have to pay out-of-pocket for the services to be provided. By instructing us NOT to submit claims to Medicare, you have voluntarily elected not to utilize your Medicare benefits, so that you may receive treatment from us.

You acknowledge that some of the services that we provide may otherwise be covered under the Medicare program, if you elect to receive services at another provider. You acknowledge that you have refused voluntarily, and of your own free will, to refuse to authorize the submission of claims to Medicare for the services we provide. You agree that neither you, nor anyone acting on your behalf, will submit any claims for services provided by us, to Medicare or any third party payer, including but not limited to any insurance company or secondary payor.

We have created this Agreement so that you may make an informed decision about whether or not you want to receive physical therapy services, or other rehabilitation services from us, knowing that you will have to pay for these services yourself. Before signing this document below, you should ask us to explain any questions that you have regarding the services to be provided, and the payments in connection with the same. You should also ask us how much the services to be provided will cost you, to the extent we have not provided that to you previously in the form of our current fee schedule.

By signing below, you acknowledge that payment in full is due at the time of service, and that payment will be your sole responsibility. Should you violate the terms of this Agreement, you agree to reimburse us for any costs or fees that we incur as a result of your violation of this Agreement.

You acknowledge by signing below that you have a full understanding of the terms of this Agreement, you have executed this Agreement voluntarily, and that you refuse, of your own free will and not based on any recommendation or advice from us, to authorize the submission of a bill to Medicare for the services that we provide.

Patient Name: ________________________________

Sign: ____
Date: _______________________________________

Accepted by Osteopractic Physical Therapy of Central Indiana, LLC

Sign:____
Date:____

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