Yorick Wijting, PT, DPT
Licensed Physical Therapist

9460 No Name Uno, Suite 250
Gilroy, CA 95020
(408) 707-0234

FINANCIAL RESPONSIBILITY

Your signature on this form indicates acceptance of the following:

☑ **Patient / Guarantor responsibility:**
Payment for all professional services rendered is the responsibility of the patient, parent, or guardian. For insurance coverage that is accepted by Yorick Wijting, PT (the "Practice") at this practice, we will prepare and submit insurance claims. The patient / guarantor remains ultimately responsible for all fees regardless of insurance coverage. Payment for all services, or the expected patient responsibility, is due when services are rendered. Payment of coinsurance and deductible is done based on reasonable estimate. If additional funds are required after the insurance claim has been processed, any balance will be billed to the patient. If the insurance company fails to process claims within 45 days from the date of service, the balance due may be collected from the patient. If insurance issues arise, it is the responsibility of the patient to contact the insurance company, group plan administrator, or employer representative for resolution. A patient's insurance policy is a contract between the patient and the insurance carrier. The Practice is not a party to that contract and cannot act as mediator with the carrier or employer. The patient will become responsible for complete payment to the practice if coverage is terminated due to lack of premium payment.

☑ **Assignment of Insurance Benefits and Financial Responsibility Guarantee**
I hereby assign any and all insurance benefits due and payable to me/us by my insurance policy for services rendered to me by the Practice. I understand and agree that this assignment is non-revocable. I authorize the Practice to release to my insurance carrier the paperwork necessary for processing payments related to physical therapy claims. I authorize any holder of my personal medical information to release to the Practice any required information needed to determine insurance benefits. If required by my insurance carrier, I agree to provide all pertinent information necessary for completion of my treatment plan(s) and for the issuance of timely payments.

I acknowledge financially responsibility for any and all charges not covered by this assignment. All co-pays must be paid at the time of service in accordance with the contracted insurance carrier agreements. If my insurance carrier sends me payment for services incurred at the Practice, I understand that I am required to deliver the full payment to the Practice upon receipt.

Patient / Guarantor Name: ____
(Last) (First) (Middle Initial)

Patient / Guarantor Signature: ______________________________ Date signed:________________

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