TheraPhysical Limited Liability Company

Acknowledgment of Disclosures and Request for

Out-of-Network Services

I, _____, acknowledge that TheraPhyscial Limited Liability Company and the providers listed below are out-of-network with my health insurance plan. I also acknowledge the following disclosures:

- Prior to scheduling my appointment, I was informed that TheraPhyscial Limited Liability Company was out-of-network and that the amount or estimated amount to be billed for services is available to me upon request;
- Upon written request, TheraPhyscial Limited Liability Company will disclose in writing the amount or estimated amount that it will bill you for the services and the CPT codes associated with the services (absent unforeseen medical circumstances that may arise);
- My out of network financial responsibilities may be in excess of the copayment, deductible, or coinsurance and I may be responsible for any costs in excess of those allowed by their carrier; and
- I should contact my carrier for further information or consultation on these costs.
- I should also contact my carrier for more information or consultation on the costs for the services of the coordinated care providers.

I acknowledge that I am knowingly and voluntarily accepting responsibility for any out-of-network financial responsibility associated with the health care services that I receive.

Dated: _____

_____

Patient Signature:

_____

Patient Name:

List of TheraPhyscial Limited Liability Company Providers

Magdalena Buczek, PT, DPT Janice Viyar, PT, DPT Priyanka Zaveri, PT, DPT Mansi K. Galvankar, PT, DPT

Kathryn Zubicki, PT, DPT Leide Santos, PT, DPT Angela Santiago, PTA