# Patient Election to Self-Pay for Services

The self-pay rates for Kinetic Physical Therapy Institute, as of January 1, 2023, are as follows and **do not include supplies or orthotics:**

- Initial Evaluation and Re-evaluation Visits (up to 60 minutes long): **$220**
- Follow up Visits (up to 60 minutes long): **$170**
- Each 15 minute increment over 60 minutes: **$20**

I, _____, the undersigned patient acknowledge that I understand and agree that:

1. Kinetic Physical Therapy Institute may be a participating provider with my insurance company (**"Company"**): _____
2. I am covered by one of the **Company** health insurance plans OR I do not have health insurance
3. The health plan under which I am covered may include benefits for some or all of the services provided by Kinetic Physical Therapy Institute OR I do not have health insurance
4. Despite the above, I do not wish Kinetic Physical Therapy Institute to submit a claim to **Company** for services provided to me by Kinetic Physical Therapy Institute OR I do not have health insurance
5. Until such time as I may otherwise advise Kinetic Physical Therapy Institute, I elect to pay for all services I receive from Kinetic Physical Therapy Institute at the capitated rates listed above.
6. By electing to self-pay for services, any payments I make to Kinetic Physical Therapy Institute will not be credited toward satisfying any deductible I may be subject to under my Health insurance plan with **Company**.
7. I understand I will not be able to retroactively ask Kinetic Physical Therapy Institute to submit claims to **Company** after I elect to self-pay for services.
8. I have read this Election to Self-Pay for Services form and have had the opportunity to ask any question I may have had about the form. Any questions I may have had about this form have been answered to my satisfaction.
9. I have freely chosen to self-pay for services after having asked Kinetic Physical Therapy Institute about payment options and having carefully considered those options.

**Signature of Patient or Legal Guardian:** _____ **Date:** _____

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual:

☐ Legal Guardian ☐ Power of Attorney ☐ Other_____

*If you would like to receive a copy of this policy, please see the front desk*