Physio4Life Patient Financial Responsibility Agreement

Patient Full Name	
Date of Birth	
Insurance Provider	
Policy/ID Number	

I, the undersigned patient, hereby acknowledge and agree to the following terms and conditions regarding my financial responsibility for medical services received at Physio4Life:

1. Minors	If specified at the end of this form, I, the parent/special guardian of the minor patient, have read carefully through this form and will undertake all the necessary duties related to the policy on behalf of the minor. I accept all financial responsibility associated with the minor's policy and healthcare at Physio4Life. I acknowledge that I, not the minor, am responsible for ensuring Physio4Life has the correct details, and that I am liable for managing all appointments and forms.
2. Insurance Coverage	I understand that it is my responsibility to provide accurate and up-to-date insurance information to Physio4Life, whether the policy is individual or through my workplace. I acknowledge that Physio4Life will make reasonable efforts to verify my insurance coverage and benefits before providing any medical services, subject to confidentiality and GDPR restrictions. I understand that insurance coverage and benefits are ultimately determined by my insurance provider. I accept that I am the person responsible for managing my account and any healthcare I receive through it, and will liaise with my insurance company as required or requested by Physio4Life.
3. Financial Responsibility	I acknowledge that I am financially responsible for all charges incurred for medical services provided to me by Physio4Life, regardless of whether my insurance company pays for all or part of the charges. This includes, but is not limited to, excess, deductibles, co-payments, co-insurance, and any non-covered services or charges. I accept that only I, and not my insurer, is fully responsible for any cancellation charges I incur.
4. Insurance Claims	I authorise Physio4Life to submit claims on my behalf to my insurance company for reimbursement of medical services provided. I understand that Physio4Life will make reasonable efforts to obtain payment from my insurance company. However, I acknowledge that Physio4Life cannot guarantee the outcome of any insurance claims or the amount of reimbursement that may be received.
5. Unpaid Balances	In the event that my insurance company denies or reduces payment for any reason, I agree to be personally responsible for any unpaid balances. I understand that Physio4Life will bill me directly for any outstanding amounts not covered by my insurance company, including cancellation charges.
6. Payment Obligations	I agree to promptly pay all invoices and statements received from Physio4Life for services rendered within 7 calendar days from the date of the invoice/statement. I understand that failure to make timely payments will result in Debt Collection

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	Services being utilised to recover all outstanding payments, with an additional fee of £100, which could affect my credit rating. I accept I would also be liable for full legal and court costs and would reimburse Physio4Life in full for these costs.
7. Payment Methods	I understand that Physio4Life accepts various forms of payment, including cash, credit/debit cards, and electronic funds transfer. I understand Physio4Life will not be storing my payment information for future transactions and therefore need to provide these each time medical services are unpaid.
8. Financial Assistance	If I am unable to pay my medical bills in full, I understand that Physio4Life can be contacted on accounts@physio4life.co.uk for possible financial assistance. I agree to promptly contact the Accounts department of Physio4Life to discuss any financial difficulties and explore available options in good time before the stated payment deadline of 7 calendar days from the date of invoice/statement.
9. Changes to Insurance Coverage	I agree to notify Physio4Life promptly of any changes to my insurance coverage, including changes in insurance provider, policy number, or any other relevant information. Failure to provide updated insurance information may result in delays in processing claims and may increase my financial responsibility. As above, I accept that I must pay in full any costs resulting from me not updating my insurance information or not communicating this to the provider.

By signing below, I acknowledge that I have read and understood the terms and conditions outlined in this Patient Financial Responsibility Agreement.

Patient full name	Patient signature	Date (DDMMYY)
Parent/special guardian full name (or write N/A)	Parent/special guardian signature (or write N/A)	Date (DDMMYY)
Witness full name	Witness signature	Date (DDMMYY)