SPECTRUM Physical Therapy & Athletic Training, LLC
Uniquely qualified to help patients break through physical barriers…

1203 River Rd. Suite 4/Edgewater, NJ 07020 & 184 Central Ave. 1st. Floor/Old Tappan, NJ 07675
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Patient Payment Agreement

I, _____, agree that it is my responsibility to understand my health insurance benefits and eligibility for physical therapy services.

I understand that my copay is $_____ per visit. I agree to pay Spectrum this copay amount at the time of each visit. Upon discharge, I agree to pay the balance within 2 months following completion of my treatment.

In the event that I exhaust my physical therapy benefits for the year or my health insurance does not cover these services, I agree to pay Spectrum $75.00 per visit for each date of service. Additionally, if Spectrum is out-of-network and my plan does not offer out-of-network physical therapy benefits, I am fully responsible for payment in the amount of $75.00 for each date of service.

Patient's Signature: _____ Date: _____