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## **INSURANCE PROTOCOL**

**MEDICARE:** Seabreeze Physical Therapy, Inc. is a Medicare Participating Provider. If you are a Medicare recipient your claim will be electronically filed. Upon receipt of payment/and or denial from Medicare, your secondary insurance will be billed as a courtesy, **one time only**. If there is a remaining balance after both insurance companies have been billed you will be responsible for this balance which will be provided for you in the form of a statement.

**COMMERCIAL INSURANCE/GROUP INSURANCE:** (Insurance through your work or private insurance) Before your initial evaluation our office staff will verify your benefits. You will be asked to sign a co-payment/deductible acknowledgement form. This will explain how much your insurance will cover and if there will be a co-payment, or deductible due. You will be expected to pay your co-pay at the end of each visit unless other arrangements are made. You will be issued a receipt upon payment.

**AUTOMOBILE INSURANCE:** Personal injury protection (PIP) usually pays at 80% of your medical bills, unless you have added the med pay option to your policy. Your insurance will be verified with your auto insurance carrier to determine coverage and amount remaining. You will be given a co-pay sheet indicating the amount of coverage and/or deductible acknowledgement form to sign. If you have an attorney representing you for your accident please provide the information on the patient information form. Your attorney will want to have updated statements and medical records from this clinic.

We review our charges on an annual basis to ensure that they are fair and competitive. As previously stated we are willing to file your insurance for out services and will advise you if any problems arise. A verification of insurance is not a guarantee of payment from the insurance company. **However, it is important for you to understand that you, the patient/responsible party, are ultimately responsible for the charges related to your therapy.**

***If you are unable to make your appointment please notify us 12 hours in advance. Failure to provide ample notice may result in a charge to your account, which your insurance will not cover.***

Having read and understanding the above listed insurance information:

I authorize treatment of my present condition requiring physical therapy.  
I authorize payment to be made directly to Seabreeze Physical Therapy, Inc.

\_\_\_\_\_  
Signature of patient or personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Patient or personal representative

\_\_\_\_\_  
Seabreeze Physical Therapy, Inc Authorized Representative

\_\_\_\_\_  
Date