FAMILY Physical Therapy & SPORTS CENTER

CASH PAY POLICY / NON-COVERED BENEFIT BY INSURANCE

PATIENT NAME: _____ **DOB**: _____

PHYSICAL THERAPY SERVICES:

Lowest Level Evaluation (97161): **$130**

Daily Treatment: **30 minutes = $50**

45 minutes = $75

60 minutes = $100

OCCUPATIONAL THERAPY SERVICES:

Lowest Level Evaluation (97165): **$140**

Daily Treatment: **30 minutes = $50**

45 minutes = $75

60 minutes = $100

SPEECH THERAPY SERVICES:

Speech Evaluation (92522): **$145**

Speech/Language Evaluation (92523): **$290**

Swallow Evaluation (92610): **$176**

Daily Treatment: **30 minutes = $70**

*KEEP IN MIND, IF RECEIVING LYMPHEDEMA CARE PATIENT IS RESPONSIBLE FOR SUPPLIES COST.

Thank you for choosing Family Physical Therapy!

_____ _____

Patient or Parent/Legal Guardian Signature Date