



INVOICE FOR NON-COVERED PRODUCTS/SERVICES

PATIENT NAME: _____

PATIENT SIGNATURE: _____

Not all services or supplies are a covered benefit in all insurance contracts. Some insurance companies arbitrarily select certain services they will not cover. Therefore, the costs for the use of these items listed here are your responsibility. Your therapist will discuss this with you prior to any services rendered or supplies being used and/or billed directly to you. Your signature is acknowledgment that you have read and understand this information.

To be filled out by Therapist

<u>Direct Supply Item #</u>	<u>Cost of Supply</u>	<u>Total Units</u>	<u>Total Amount Due</u>
Theraband	\$2.00 per foot		
Dupel Iontophoresis Pad	\$8.00 per 1 unit		
Hybrosis	\$10.00 per 1 unit		
Electrodes 2 x 2	\$6.00 per 1 unit		
2 x 3.5	\$10.00 per 1 unit		
3 x 5	\$25.00 per 1 unit		
ECT = Electric Current Therapy	\$20.00 per session		

Please remit \$ _____ for non-covered products/services used during your course of treatment.

Please note that we disclosed this financial policy to you on your first visit. Should you have any questions, please feel free to contact us at (607) 217-0827.

Thank you,

OAKDALE PHYSICAL THERAPY & FITNESS
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(607) 217-0827
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