Insurance Company Name:	
Insurance Company Phone Number:	

Date Verified _____

Total Annual Deductible: **Amount Met:**	
Total Annual Out-of-Pocket: **Amount Met:**	
Co-Payment Amount:	
Co-Insurance Amount:	

Once reviewed with the New Life Physical Therapy Patient Services team, you could then determine:

Estimated cost/visit <u>until</u> deductible is met : _____

Estimated cost/visit <u>after</u> deductible is met : _____