PATIENT FINANCIAL POLICIES

TO OUR VALUED PATIENTS:
We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. To accomplish this, we need your assistance and understanding of our payment policy.

1. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. **You will be responsible for paying for your visits until your deductible is met. Once your deductible is met, you will be responsible for your co-pay or co-insurance.**
2. **As a courtesy, we will verify your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan. If your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received.**
3. Not all services are covered in all contracts. Some insurance companies select certain services they will not cover. **These services, if applicable, are your responsibility**.
4. If you have more than one insurance, you will be responsible for disclosing all insurances to us, as well as alerting each insurance of any additional coverages (this is called a coordination of benefits). Should you neglect to disclose this to any of the parties (the clinic or your insurances), claims could process incorrectly. You will be responsible for any unpaid claims that are the result of a lack of coordination of benefits.
5. We highly recommend you also contact your insurance carrier and check into your coverage for physical therapy services. Do not assume that you will not owe anything if you have more than one insurance policy.
6. **The estimate provided at time of service is not an exact calculation of your actual costs** and does not reflect all of the terms, conditions, limitations, and exclusions that may apply to your coverage. Your actual costs will vary depending upon the specifics of your benefit plan and the services and supplies you receive.
7. If this injury is work related and a Workers Compensation claim has been initiated, we require that you provide us with a claim # to ensure payment of the account. This must be done on your first visit with us.
8. For liability cases, where another party is responsible, you need to provide us with all the billing information. If you have an attorney, please provide this information on the registration form. **It is our policy that a letter of protection must be received from your attorney within the first 2 weeks of your treatment. Without this letter, you become responsible for the account in full.**
9. Our office requires **a 24-hour notice for cancellation of appointments;** you can call and leave a message on the answering machine if needed. We realize conflicts with work, other activities, or unexpected illness may require you to call and reschedule, however, there may be a $35.00 charge for a missed appointment without notification to the office.
10. Payment is due at time of service unless you have signed a monthly payment contract through our Billing Office. Payments made on account will be applied to the oldest outstanding balance first. Unpaid balances may be assessed a finance charge.
11. We reserve the right to terminate services if payments are not made in a timely fashion.

Again, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. Should you encounter problems making payments on time, we encourage you to contact us promptly for assistance in setting up a payment plan. If we do not receive payment from you according to agreement and/or the arranged payment plan notice we sent to you, you agree to be responsible for any expenses incurred in collecting the patient's account balance, including all fees, court costs, attorney fees and all other collection related expenses.

By signing below, patient/responsible party acknowledges that he/she has read, understands and hereby accepts the above obligations and agreements.

Patient Name: **Signature:** **Date:**

Information below is *required for treatment of a minor or a patient who does not have their own power of attorney.*

*******PERSON SIGNING BELOW MUST FILL OUT ATTACHED GUARANTOR INFORMATION**********

Name of Parent or Legal Guardian: **Signature:**

Date:_____

GUARANTOR INFORMATION

IF YOU ARE SIGNING OUR FINANCIAL POLICY OR INTAKE FORM AS THE PERSON OR LEGAL GUARDIAN OF THE PATIENT LISTED ON THIS FORM, WE MUST HAVE THE FOLLOWING INFORMATION:

Name of Parent or Legal Guardian: _____

Male Female DOB:_____ SSN:_____

Mailing Address: _____ City/State: _____ Zip: _____

Phone: Home: _____ Work: _____ Cell: _____

Email Address: _____

Place of Employment: _____ Occupation: _____

Employment Address: _____ City/State: _____ Zip: _____