

FINANCIAL POLICY AND CONTRACT

Dear Patient,

We will bill your insurance for the physical therapy services. Our office staff is experienced and will help you get maximum benefit from your policy. You must read your policy and be familiar with its main features. Ask our Office Manager for help to understand its benefits. We will verify your insurance coverage by your second appointment and notify you if we need more information. 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.

Please read and sign the following Policy and Contract. Ask the Receptionist or Office Manager if you have any questions.

1. Your policy may pay less than our customary fee. Not all services are a covered benefit in all policies. You should discuss payment of the balance with the Office Manager.
2. The insurance company is your company. Your insurance policy is a contract between you, your employer and the insurance company. Do not hesitate to call them if you have a question regarding payment. This document is a contract between you and Spine & Sport Physical Therapy.
3. We should receive payment from the insurance company within 45 days. After 45 days, you are responsible for the balance.
4. You must make arrangements to pay the percentage not covered by your policy, if your policy pays less than 100%. You will receive a statement (at least monthly) indicating the balance due. Payment is due at the time services are rendered. We accept cash, checks, Mastercard or Visa.
5. If you have a co-pay, you should pay when you arrive for each appointment.
6. By signing this document, you are promising to pay any balance left after insurance proceeds are received by Spine & Sport Physical Therapy.

Cancellations: Please notify us as soon as possible if you must reschedule your appointment. 24-hour notice is appreciated. If a cancellation is made the same day as the appointment and the time cannot otherwise be filled, a \$30.00 charge will apply.

No Shows: Missed appointments without notification are charged \$30.00 due to the scheduling inconvenience. This is **NOT** paid by insurance.

Litigation & Third Party Payer: We do not see patients with the expectation of payment contingent on the outcome of any litigation. If you are anticipating payment for services by another party's insurer, we still expect payment when the service is rendered. We will bill your insurance on your behalf. You should pay any percentage not covered by your own policy.

(OVER)

Interest Charge:

Services paid for within ninety (90) days of the service date are not subject to an interest charge. A 1.5% per month interest will be charged to all balances over ninety (90) days.

Attorney's Fees:

You agree to pay, in addition to the balance due and the applicable finance charge, an amount equal to thirty-three and one-third percent (33-1/3%) [or the maximum permitted by law, whichever is less] of the balance due as attorney's fees if this account is referred to an attorney for collection.

I understand and agree (regardless of my insurance status) that I am ultimately responsible for the balance of my account for any professional services rendered.

I certify that all information is true and correct to the best of my knowledge. I will notify you of any changes in my health insurance status of the above information.

PLEASE SIGN → _____
Signature Date

I certify that I have read both sides of this document and agree to the terms and conditions herein.

PRINT FULL NAME _____

PARENT(S), IF PATIENT IS A MINOR _____

ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be paid directly to the Physical Therapy practice and agree that I am financially responsible for all non-covered services including interest, cancellation, and no-show charges. I also authorize the physical therapist to release any information required to process insurance claims.

Please feel free to discuss any facet of your medical insurance coverage with us.

AGREED:

PLEASE SIGN → _____
Signature Date

Signature of Insured, if not the Patient Date