"Providing Freedom from Pain"

Financial Policy and Payment Plan Agreement

TO OUR VALUED PATIENTS:

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. We strongly encourage you recommend you to confirm your insurance responsibility with your medical Insurance Company. Should the information they give you regarding your coverage differ in any way please bring this to our attention immediately.

If a Deductible or Co-Insurance applies to your policy, the quoted cost per visit is only an estimation. When additional patient responsibility is due after your claims have processed, you will receive a statement. In the event of an over payment, after all the dates of service have been processed by your Insurance, a refund will be issued accordingly.

Please read carefully:

1. **PAYMENTS**- Copayments and payment for services are due at the beginning of **EACH** visit. If a Deductible or Co-Insurance applies to your policy, the quoted cost per visit is only an estimation. When additional patient responsibility is due after your claims have processed, you will receive a statement. In the event of an over payment, after all the dates of service have been processed by your Insurance, a refund will be issued accordingly.
2. **IN NETWORK/OUT OF NETWORK**-Your insurance is a contract between you, your employer and your insurance co. We are a participating provider for most insurance companies. If we are in network, we will charge you no more than our contractual rate with your insurance company if applicable. If we are out of network with your insurance company and your claims are submitted to your insurance company, you will be responsible for all reasonable and customary charges as indicated on the explanation of benefits received from your insurance company. For more clarification on this, please speak with our Income Manager.
3. **BENEFIT LIMITS**- Some insurance plans have a financial or visit limit for physical therapy services. It is ultimately your responsibility to know your benefit limits. We have procedures in place to help you stay beneath any limits, but again it is ultimately your responsibility to keep track of your limits as if you exceed your limit, you will be responsible for charges not paid by your insurance company due to the exhaustion of your benefits.
4. **MEDICAL SUPPLIES/DME**-You will not be billed for any service not covered by your insurance company; however, we will not bill your insurance company for any medical supplies or DME (durable medical equipment) received. Payment for any supplies received, will be your responsibility prior to issuance of the supply.
5. **WORKERS COMPENSATION**-If your injury is work related, and a Workers Compensation claim has been initiated, you must provide our office with your claim number, adjuster's name and phone number before your initial visit. Please be advised that if your account is not paid by your comp. carrier, you will be responsible for all charges within 30 days of notification.
6. **LIABILITY CASES**-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 this office's policy that a letter of protection and a $500 deposit must be received from your attorney before the first visit. Without this letter and deposit, you will be responsible for the account in full.

FOR YOUR CONVIENANCE, PLEASE SELECT A PAYMENT PLAN			
Plan #1 Pay once a month Paying upon **first visit** of the month.	**Plan #2** Pay Once a week Paying upon **first visit** of week	**Plan #3** Care Credit Paying once a month	**Plan #4** Paying **before every** session (HSA Account)
Initials	Initials	Initials	Initials

PATIENT HAS ZERO RESPONSIBILITY Patient Initials______________________Receptionist Initials__________________

I have read the above policies and agree.

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Patient/Parent and or Gaurdian Signiture Date **Print Name Date**