MARYSVILLE PHYSICAL THERAPY
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FINANCIAL POLICIES & AGREEMENT

PLEASE READ CAREFULLY

Thank you for choosing us as your physical therapy provider. We want to provide you with the best possible outcome for your injury. We want you to understand that in addition to your commitment to your physical therapy program as well as compliance with our financial policies that it enables us to give you the highest quality of care.

- Our office does participate in a variety of insurance plans. You will need to notify us if there are any changes in your insurance information during your episode of care. We will check your benefits for you at the time of your first visit and as we are notified of changes in your plan.
- Please understand that final coverage is always determined by your insurance company when the claim is processed. **Our information is not a guarantee of payment, benefits, or a contractual agreement.**
- We will do our utmost to notify you ahead of time of non-covered services; however we are not aware of the specifics and/or exclusions of your individual insurance plan.
- All co-pays, deductibles and cash services are payable at the time services are rendered. For your convenience you may choose to pay weekly and we accept cash, checks, money orders and credit cards. We can estimate your payment responsibility for most insurance plans. Please be prepared to pay on your account. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the payment to us.
- We will bill your primary and secondary insurances for you solely as a courtesy to you. Your account will be adjusted accordingly as the claims are processed by your insurance company.
- A refund, if any, will be refunded to you within one month after all dates of service for your episode of care have been processed by your insurance company.
- In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company.
- The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Workers Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.
- You are assigning payment of benefits to Marysville Physical Therapy. You are responsible for any co-pays, deductibles, co-insurance, and non-covered services during your episode of care.

- Our office is happy to discuss questions regarding your insurance with you. We also encourage you to contact your insurance company regarding your benefits or questions. (Phone number will be on your card.)
- We can provide you with an itemized statement showing your charges, payments, adjustments and coding. We can only file a claim for the services and diagnosis for our treatment. To request a change solely for the purpose of obtaining reimbursement from your insurance carrier would be inappropriate and could be considered a fraudulent act on our part.
- We will bill you on a monthly basis. We expect payment to be made within 30 days. Payment plans may be requested.
- Past due accounts will be turned over to an outside collection agency and a 35% collection fee added to the balance. We will notify you by letter and allow you 30 days to provide payment. You are responsible for notifying us of any address changes.
- We will add a $45.00 service charge for all returned checks. Payment for returned checks must be in the form of cash, money order or credit card.
- There will be a charge for medical record requests made by the patient or the patient's representative. Charges will be added to your account as well as payment for such. There is no fee for records used in the continuation of your care and sent directly to the requesting provider's office. There will be a fee for records requested by attorneys or if you request multiple copies of your records.
- If you no show an appointment three (3) times you may be discharged from our care and notification sent to your physician regarding your noncompliance with your care.
- Any balances not paid from one episode of care will be expected prior to your next episode of physical therapy in our office.

Your signature below certifies that you understand and agree to the above policies. You agree to pay for all charges or non-covered services provided to you. You understand that if you give false information, withhold information or fail to report changes promptly, you will be breaking the law and can be prosecuted and/or have services discontinued. You understand and agree that if you fail to make any of the payments that you are responsible for in a timely manner, you will be responsible for all costs of collecting the monies owed, including collection agency fees, court costs, and attorney fees.

Patient Name (printed) _____DOB:_____
Parent/Guardian relationship_____
Signature:_____Date:_____