

FINANCIAL POLICY

Thank you for choosing us as your physical therapy provider. We are committed to your treatment success. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, **which we require you to read, initial and sign prior to receiving any treatment.**

**CO-PAYS THAT ARE REQUIRED BY YOUR INSURANCE POLICY ARE DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECK, VISA AND MASTERCARD.**

X **Regarding Insurance**

We bill your insurance company as a service to you. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. You must supply us with a copy of your insurance card and a physician's prescription. Freedom will not be responsible for mistakes being made due to missing or incomplete information. **By signing below, you are responsible for any amount not covered by your insurance carrier and agree to pay such amounts within thirty days from the denial date.** Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. If after thirty days from the date your insurance company has paid and we have not received payment in full from you on your balance, we reserve the right to send your account to collections.

Regarding Insurance plans where we are the participating provider, all co-pays are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to above paragraph.

X **Usual and Customary Rates**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Unless discounted rates are predetermined by contractual agreement, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

X **Workers Compensation, Accidental Injuries, Liabilities**

Most Workers Compensation and Personal Injury accidents are covered **100%** in our office. If you are claiming workers compensation or filing claims to a liability carrier, you must still provide us a copy of your primary insurance card and a copy of a physician's referral. For Workers Compensation cases, we must have prior authorization from your employer to begin treatment. With Liability Cases, you must sign all forms relating to your case. Any attorney handling your case must sign our lien form. In the event payment for your claim is denied by a workers compensation or liability carrier, we will file claims with your personal health insurance. If your claim is denied and your personal health insurance will not pay for services rendered, you will be required to pay on your account consistent with our financial policy and finance charges.

X **Minor Patients**

A parent or legal guardian must accompany minors at time of initial visit. The adult accompanying a minor or the parents (or guardians of the minor) is responsible for full payment. If the parents are separated and both legally responsible for treatment of their minor child, provide complete information from both parents so we may bill the appropriate insurance. The parent or guardian that accompanies the minor to our office will be held wholly responsible for payment should any dispute over payment arise. For unaccompanied minors that are required to pay a co-pay charge, a pre-authorized approved Visa, MasterCard may be obtained or payment by cash or check at the time the service will be required.

X **Missed Appointments**

Unless cancelled at least **24** hours in advance by telephone, our policy is to charge for missed appointments at the rate of **\$100.00**. Please help us serve you and others better by honoring scheduled appointments.

X **COPAYS**

All co-pays are due at the time of visit. Freedom Physical Therapy reserves the right to refuse treatment to any patient not paying their co-pay at time of visit.

If you have insurance, balances will be considered current from the date your insurance pays its portion. You will have a thirty-day grace period to pay your portion of the services. There will be a **\$20.00** service charge for all returned checks.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

X _____ Date _____

Signature of Patient or Responsible Party