

FINANCIAL POLICY

In order to keep your cost of physical therapy services to an absolute minimum, Health In Balance Physical Therapy, LLC has adopted the following financial policy. This policy applies to all clients and specifies responsibility regarding payment for services rendered.

HEALTH INSURANCE

The client's health insurance is a contract between client and insurance company, and is a vehicle to help pay for medical care. As a service to you, we will call your insurance company prior to your first visit in an attempt to determine your benefits (if you provide us with the information before you come in). Please keep in mind that insurance companies DO NOT guarantee payment for service over the phone, and you are ultimately responsible for any expenses incurred if your insurance does not pay what you expected they would. It is in your best interest to be aware of your physical therapy benefits before you come in for your first appointment. We will submit claims to your insurance company if you provide us with current insurance information. Depending on the insurance company, our fees may or may not be considered usual and customary. Insurance companies use many different equations to form a fee schedule.

Clinic policy requires that all anticipated co-pays, coinsurance and visit fees be collected at time of service. These payments may be applied against any applicable unmet deductibles. If your insurance company pays more than anticipated, your account will be credited. We accept cash (exact amount is appreciated), personal checks, and credit cards (Visa and MasterCard). The clinic charges a \$30 fee to you for any NSF checks received, which is payable before or at the time of your next scheduled visit.

The client is ultimately responsible for timely payment of services rendered. Any insurance balances outstanding after 60 days are due in full by the client. It is the client's responsibility to negotiate with the insurance company for any unpaid services.

PRIVATE PAY

If you will be paying for visits privately (not through an insurance company), clinic policy requires payment at time of service. Acceptable methods of payment are cash, check, or credit card. Please be prepared to make payment at the time of your visit. If you have questions regarding clinic fees, please contact our office staff.

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ASSIGNMENT OF BENEFITS (client signature required for clinic to bill insurance)

Since my health insurance may cover the cost of service, I hereby authorize Health In Balance Physical Therapy, LLC to release to my insurance company and/or associated professionals any information from my medical records which may be necessary to determine benefits payable under my policy. This information may be transmitted electronically. I authorize payment directly to Health In Balance Physical Therapy, LLC for the benefits otherwise payable to me for the amount which covers but does not exceed services delivered. I guarantee payment of any and all charges incurred for services rendered which are not covered by this assignment or by insurance benefits.

Date: _____ **Client Signature:** _____

FAILURE TO PAY

Our staff of physical therapy clinicians and office support professionals provide confidential, compassionate, and effective care to our clients. We adhere to the highest standards of ethical practice and service your needs in good faith. In order to continue our services to you and other members of our community, we expect payment for services rendered in a prompt manner. If payment is denied by your primary insurance company and you have a secondary insurance company they will be billed. If extenuating circumstances arise, please consult with our office staff regarding an acceptable payment arrangement. Failure to do so may result in the need to curtail further sessions until the financial situation is resolved.

A late charge of \$25.00 will be added to the patient's account if a patient balance is not paid by the 20th of the month in which the amount is due. If it becomes apparent that a client does not intend to satisfy his/her financial responsibility, a collection agency or attorney may be contacted to pursue collection of the account. A collection fee will be charged to the client's delinquent account for collection agency services.

I have read and understood the above financial policy

Date: _____ **Client Signature:** _____