FOOTHILLS
Physical Therapy

FINANCIAL POLICY STATEMENT

It is the patient's responsibility to know their insurance policy and its limitations. The patient agrees to pay for all portions of services due in full at the time services are provided by our office. Although we check the patient's insurance benefits as a courtesy, it is crucial that the patient is personally aware of his/her insurance benefits. If the patient's insurance company denies service for prior authorization or no referral on file, the patient is responsible for the timely payment of services. The patient is required to present a valid insurance card at his/her first visit and as needed throughout care. If there are any changes to the patient's insurance, he/she is responsible to advise us of those changes and present the new card.

Supplies: We do not bill supplies to the patient's insurance company. The patient will be responsible for all supply costs at time of service.

Commercial Insurance Carriers: We bill most insurance carriers for the patients. Any outstanding balances, co-payments and deductibles are due at check in. If any processed claims go towards the patient's un met deductible we ***estimate*** the patient will be responsible for $100 to $120 a visit. We require that the patient pays $100 to $120 at each appointment until the deductible has been met. Any overpayment will be applied to future visits or returned to the patient after treatment is completed. Any underpayment will result in a balance and will be invoiced to the patient.

Self-Pay: Our self-pay option is $130 for the initial appointment and $95 thereafter. Payment is due at the time of service. If chosen to do self-pay all payments will not go towards insurance.

Medicare and/or Medicaid: Our office is a Medicare/Medicaid participating provider and we will bill Medicare/Medicaid for the patient. We will bill the patient's secondary insurances that automatically crossover through the CMS (Medicare/Medicaid system). Any outstanding balances and deductibles are due prior to the patient's appointments. Any coinsurance and non-covered service will be due as service is rendered.

Accident Claims: If the patient's visit is accident-related, we will need the claim/case number and carrier/adjuster's name prior to the first visit in order to obtain prior authorization for treatment.

• Motor Vehicle Accident (MVA): We do not accept 3rd party payers. We will bill the patients personal motor vehicle insurance with med pay, however $100 payments are due at each appointment until we receive payment from the patient's motor vehicle insurance.

• Worker's Compensation: Your works compensation carrier will approve physical therapy and pay for services that they determine is pertinent to your rehabilitation in regards to your work comp injury. If at any time your works compensation carrier determines that a service that is being provided is not reasonable and necessary and subsequently denies payment for a particular service performed by Foothills Physical Therapy, the patient will be held responsible for payment. Foothills Physical Therapy will alert the patient with any uncertainty in regards to the authorization process and any particular services that may be considered non-covered.

Cancellation & No Show Policy: In order to be respectful of other patients**, *all patients*** are required to give at **least 24 hours** advanced notice when canceling or rescheduling an appointment. One warning will be given for your first late cancel and/or no show. After that warning we have the right to charge you a $40.00 fee. If you are charged a $40.00 fee you are required to pay that fee prior to your next appointment.

Methods of Payment: Our office accepts the following payment methods: cash, personal checks, VISA, MasterCard, Discover, and American Express credit cards.

We will assess a $20.00 NSF charge on all returned checks.

Any other arrangements made with the front office will be as follows; Monthly payments are required to pay off the patient's account balance within 3 months of the first invoice date, with an account balance due of no more than $1,000 to avoid being sent to collections. If the patient's balance has reached $1,000 treatment will be stopped unless otherwise directed by the treating therapist. If the patient's account is not paid according to terms, the patient understands that our office reports to an outside collection agency.

The patient is ultimately responsible for all fees for services. I understand and agree to the FINANCIAL POLICY STATEMENT above.

Signature _____ Date _____