OFFICE/FINANCIAL POLICY AND PROCEDURES

We are committed to provide you with the best possible care. If you have physical therapy benefits, we are happy to help you receive the maximum allowable benefits. In order to achieve these goals, we need your cooperation and understanding of our policies.

Co-payments or payments are due at the time of service. Payments can be made by credit card, personal check, or cash. Patients with co-insurance will be billed as the information is received from your insurance company.

Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. As a courtesy to our patients, our office will verify your benefits with your insurance company. Since our relationship is with you, not your insurance company, we strongly recommend that you also verify your therapy benefits with your insurance company. Any inaccurate information given to our office by an insurance representative coverage will be your responsibility.

If you do not have your insurance card for verification purposes, you will be responsible for payment for services in full until the current insurance information can be verified. No visits will be back dated to the insurance company for any reason.

You are responsible for obtaining a Primary Care Physician referral or prescription if required by your insurance company. If you do not have the required referral or prescription for your visit, you are responsible for payment of services until the referral is obtained. No visits will be back dated for any reason.

Some insurance policies have restrictions on therapy benefits including, but not limited to, an annual number of visits or consecutive days of treatment. You are responsible to keep track of these restrictions. If insurance does not cover treatment our private pay rate is $_____/session.

We file all insurance claims for you. In most cases, insurance companies will make payment to our office directly. If you receive payment for our services, you are responsible for payment to our office.

There will be a $35.00 service charge for all returned checks.
Please remember to make appointments and set aside time for each treatment session. In the event you are running late or need to cancel or reschedule appointments, we expect that you make every possible effort to contact our office in a timely manner.

If you have any questions, please do not hesitate to ask. We are here to assist you in any possible way.

Signed: _____ Date: _____

Relationship to Patient: _____

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