ONPOINT PERFORMANCE
PHYSICAL THERAPY & REHABILITATION

FINANCIAL AGREEMENT

INSURANCE

Your insurance coverage is a contract between you and your insurance company, and it is your responsibility to know your insurance benefits. As a courtesy, we will bill both your primary and secondary (if applicable) insurance companies. We will submit claims and assist you in any way we reasonably can to assist you in processing the claims; however if our office has not received payment from insurance after 90 days, the balance will become patient responsibility. All medical benefits will be assigned to OnPoint Performance LLC for your treatments at our facility and I authorize OnPoint Performance LLC to release all information necessary to secure payment from insurance companies. ____**initials**

PATIENT RESPONSIBILITIES FOR PAYMENT You are responsible for payments including all co-payments, co-insurance, deductibles, services not covered by your insurance, as well as collection or attorney fees. Outstanding balances will be invoiced and mailed at the beginning of each month. Payments are expected within 30 days of receipt. We accept all major credit cards, HSA, personal checks or cash. You can call payments in directly or place payments in the mail along with the invoice. ____**initials**

NON-PAYMENT A finance charge computed at the rate of 1.5% per month or APR of 18% will be imposed on each item of your account for each item which has not been paid within 90 days. The finance charge is computed by applying 1.5% to the 'past due balance' of your account. The 'past due balance' is calculated by taking the balance owed of more than 90 days and subtracting any payments or credits applied to the account during that time. You understand the finance charges are not billable or payable by insurance companies.

Unless reasonable arrangements are made with our office, failure to pay your account in full within 90 days after all insurance obligations have been fulfilled, will result in your account being referred to a collection agency or attorney for collection, which may affect your credit. In the event this happens, I shall pay all attorney fees, all other legal fees and collection agency's costs related to the encounter.____**initials**

We understand that financial circumstances can affect our patients. If you are unable to fully pay your bill within 90 days, please call our office to make arrangements with our office manager. We will make arrangements to pay your bill with equal monthly installments over 4 months.

MEDICARE

I authorize any holder or holder of medical information about me, to release information to the Health Care Financing Administration and its agents, any information needed to determine these benefits and relatable services. We strive to inform our patients of any services that will not be covered. If there are services that may not be covered, we may ask you to sign a separate form, an Advanced Beneficiary Notice, which will list our fees and will notify you of your financial responsibility for these non-covered medical services.

PATIENT/GUARANTOR SIGNATURE_____

DATE:____/____/____