Financial Policy

As a courtesy we will bill your primary and secondary (if applicable) insurance companies. You are responsible for any deductible, co-pay and/or any balance due after insurance has processed your claims. Your insurance is a contract that exists between you and the insurance company. Please see insurance information below. If there are any questions about your bill, it is important that you communicate with us as soon as possible. Please contact our office to discuss a mutually agreeable payment plan that will not jeopardize your credit. If you do not have insurance, we will require a deposit on account at the time treatment is rendered.

Please advise the receptionist of any changes that may affect your billing: i.e. changes of employment, address and/or new insurance. If you have a change in your insurance policy, please notify the receptionist within 10 days. If your insurance policy is not updated within this 10 day range, you may be responsible for treatment charges.

Returned Checks: If we receive an NSF check back from the bank there will be a **$25.00** charge to your account.

Motor Vehicle Accidents: If you are involved in a MVA, we will bill the auto insurance. You are responsible for keeping us informed of any decisions or changes that could affect the outcome.

Missed Appointments: Please give a 24 hour notice for any appointment you cannot keep. A **$50.00** charge will be incurred if you fail to notify us. _____ **(Initial Here).** If a patient fails to appear for two scheduled appointments, physical therapy may be discontinued and your physician will be notified.

Timeliness: We value your time and don't want to keep you waiting, but occasionally, we are delayed by an unexpected event with another patient. Please be assured that the quality of your care will not suffer. If you arrive late, your treatment will end at its scheduled time in order to avoid delays for patients after you.

Medical Supplies: Most insurance companies don't cover durable medical equipment as a benefit. Therefore, if these supplies are not covered by your insurance company, we will ask for payment in full at the time of pick up. We accept cash, check or Visa/MasterCard for payment.

Patient Consent and Release: I authorize my insurance benefits to be paid directly to South Whidbey Physical Therapy. I am financially responsible for any balance due. I authorize physical therapy treatments.

Signature: _____ **Date:** _____

Liability Release

I wish to receive physical therapy on the premises of Island Athletic Club. I agree to assume all risk involved during the use of the facilities and equipment, and further agree to hold harmless Island Athletic Club, South Whidbey Physical Therapy, and their staff from any and all claims, suits, losses for related causes of action for damage or injury to myself or my property which may arise in any way from such use.

Signature: _____ **Date:** _____

At Island Athletic Club
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