Ridgefield Physical Therapy
Billing Policies
Updated: December 2020

As a courtesy to our patients, Ridgefield Physical Therapy will bill your insurance company if we are provided with all the necessary information. To avoid any confusion our policies are listed below.

IF YOU HAVE PRIVATE INSURANCE: _____initial
(Example: Medicare, Blue Cross/Shield, UHC, Health Net, CUP....)
To ensure timely payments, you MUST identify the following information on the first visit:

A. Name of insured
B. ID number/group number and/or claim number
C. Insurance company billing address and telephone number
D. Provide Ridgefield Physical Therapy with a copy of your insurance card

If no payment is received from your insurance within 90 days, we will require payment from the patient to keep the account from going to collections (unless other arrangements are made).

AUTO ACCIDENT/THIRD PARTY CASES: _____ initial
We will bill auto insurance and other liability insurances if we are provided with the following information:

A. Name of insured
B. Claim number and Date of Accident
C. Insurance company billing address
D. Adjuster's name and telephone number

It is your responsibility to be informed of the PIP Amount available throughout your treatment. We require your health insurance card on file in the even your PUP exhausts. In cases where an attorney is involved, we require a Lien Agreement be signed to protect any balance for the services provided. If your attorney refuses to sign the Lien Agreement we still require payment. If you are injured by someone else and don't have PIP coverage, we will cooperate with you in processing your claim. You are still responsible for payment whether or not you collect from the auto insurance company.

ON THE JOB INJURIES: _____ initial
If you are injured on the job and you have an open claim, we will bill the worker's compensation insurance and no payment by the patient is required. You must provide us with the following:

A. Worker's Compensation insurance company
B. Claim number and date of injury
C. Adjuster's name and telephone number

If your claim is denied by worker's compensation, we will bill your private health insurance- as long as you provide our office the pertinent information listed above. You are then responsible for any balance not covered.

CASH: _____ initial
As a courtesy to our patients who do not have physical therapy benefits, we offer a discounted rate when payment is received on the day services are provided.

PATIENT STATEMENTS: _____ initial
You will receive a patient statement **after** we receive an explanation of benefits from your health insurance. The services printed on the statement may not correspond with the amount that is due because we will only bill for dates of service listed on the most recent explanation of benefit. You will also receive an explanation of benefits from your insurance stating the amount you owe. If you are not insured, our staff will be glad to arrange an acceptable payment plan. No credit will be extended to patients having a delinquent account or who have been referred to a Collection Agency for payment. If this account is assigned to collections, you will be responsible for any collection cost, attorney fees and interest that may apply. Responsibility for payment of your account remains with you at all times; and although you may have an insurance claim pending, ultimately, we must look to you for payment regardless of the circumstances involved. If your check is returned, there will be a $25 charge. All future payments will then need to be paid in credit card or cash. Please contact us if a problem arises.

- **LATE FEES**: _____**initial**. All balances will be subject to a .75% per month; from date of patient statement received.
- **STATEMENT**: I would like to receive my statement via _____ Paper _____ E-mail _____**initial**

INVENTORY ITEMS: _____ initial
You will be required to pay for inventory items and also orthotics on the day you receive them from our office. We will bill your insurance company if requested but you are ultimately responsible for any balance due, including tax, regardless if the insurance discounts the item.

PATIENT OR PARENT/GUARDIAN AGREEMENT: _____ **initial**
I authorize release of information requested by my insurance plan for payment
I understand that I am responsible for any balance due
I authorize Ridgefield Physical Therapy, LLC to release any medical information to medical providers and their staff, insurance company, and management groups pertaining to my physical therapy benefits, diagnoses, and treatment.
I acknowledge that a copy of the Notice of Privacy Practices Policy is available at the front reception desk.
I agree to comply with the terms and conditions as outlined in the Patient Registration form.

_____ _____
Signature: Patient/Parent/Legal Guardian Date
Print Name: _____