Mt. ASCENSION PHYSICAL THERAPY

COLLECTION/PAYMENT POLICY

It is the policy of Ascension Physical Therapy to have a Financial Policy that clearly outlines patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care and minimizing administrative costs. This Financial Policy has been established with these objectives in mind, and to avoid any misunderstanding or disagreement concerning payment for professional services.

- Our office participates with numerous insurance companies and managed health care programs. For patients that are members of one of these plans, our business office will submit a claim for services rendered. The patient must complete all necessary insurance information, including special forms, before leaving the office.
- If a patient has insurance that we do not participate in, our office is happy to file the claim upon request; however, payment in full is expected at the time of service.
- It is the patient's responsibility to pay any deductible, co-insurance, co-payment, or any portion of the charges as specified by the plan at the time of visit. Any medical services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of visit. This includes any worker's compensation claim or motor vehicle accident related claims that may be denied by the insurance company.
- Payment for services can be made with cash, check, MasterCard, Visa, or Discover.
- _____ *(Initial)* **No shows are not acceptable**. We have several patients on our waiting list to get in for physical therapy. Mt. Ascension Physical Therapy reserves the right to charge **$50 FOR ANY NO SHOW.**
- _____ *(Initial)* Mt Ascension Physical Therapy also reserves the right to charge **$25 for cancellations with less than 24 hour notice**. 24 hour notice is requested for any cancellation.
- _____ *(Initial)* If a patient feels that he or she may require financial assistance, notify the practice receptionist before you see the physical therapist, for referral to the appropriate individual. If financial assistance is needed it is our policy to work with you to find a payment amount that is agreeable to both your situation and our office. Account balances over $500 that do not have at least 10% of balance paid each month may be subject to an interest charge (12% per annum) being assessed to the account. Patients that do not have insurance are expected to pay for professional services at time of service unless prior arrangements have been made with us. Accounts that have no payment activity for a period of 6 months (180 days) may incur a $20 late fee per month.
- _____ *(Initial)* I understand that any unpaid balance will be placed for collections with any third party collection agency.
- It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice before the visit. Visits may be rescheduled, or patient may be financially responsible due to lack of the referral.
- It is the patient's responsibility to provide us with current insurance information and to bring their insurance card to each visit.
- Our staff is happy to help with insurance questions relating to how a claim was filed, or regarding any additional information the carrier might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company's member services department (number is on the insurance card).
- The adult accompanying a minor, (18 years and younger), and the parents (or guardians of the minor) are responsible for payment at the time of service.
- _____ *(Initial)* Phone call/Email Policy: By initialing, you are authorizing us to call you at whatever phone number(s) you provide, regarding outstanding balances and any other matters related to your treatment at our facility.

Our practice firmly believes that a good physical therapist/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the business office. We are here to help you. Please sign that you have read and agree to this Financial Policy

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Signature of Patient/Responsible Party Date

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Print Name/Relationship to Patient