Insurance Policy

As a patient receiving physical therapy services from our office, it is ultimately your responsibility for paying the financial balance not covered by your primary and/or secondary health insurance. Verification of your eligibility and/or benefit information by our office is not a guarantee of payment by your health insurance. Your benefits will be determined once a claim is received and will be based upon, among other things, your eligibility, any claims received during the interim period, and the terms of your certificate of coverage applicable on the date services were rendered. Our office will file each claim with your health insurance and once the explanation of your benefits (E.O.B.) is received by our office, any outstanding balance and deductible will be billed and then mailed directly to you at the mailing address you provided to our office.

It is the patient's responsibility to inform our office of any updates to their health insurance information, current address, and additional contact information for our office records. Failure to provide accurate and up-to-date information may result in the patient bearing the financial responsibility, if any, for the financial balance. _____ (***initial***)

If you have health insurance that is primary or secondary to Medicare, you are responsible for providing accurate and up-to-date information of the other health insurance company to us for verification of your coverage. If Medicare is your only health insurance, you will be responsible for the annual Medicare deductible and 20% of Medicare's allowed fees. _____ (***initial***)

If you require physical therapy due to an injury or accident and you have Workers' Compensation, you are responsible for completing and filing required injury/accident claim forms with your employer prior to your scheduled physical therapy examination. At the time of your schedule physical therapy examination, please provide the following information:

1. Name, address, and phone number of your employer or automobile insurance,
2. Claim number,
3. Date of injury/accident,
4. Name and phone number of the adjuster

We kindly ask that you provide your health insurance information prior to your scheduled physical therapy examination. We will only submit your invoice(s) for your physical therapy if workers' compensation claim declines reimbursement for the services previously rendered.

You are responsible for providing an updated referral for physical therapy prior to and during your plan of care from your referring healthcare provider. _____ (***initial***)

If you are unable to arrive for your previously scheduled physical therapy appointment, kindly contact our office **24 hours** prior and please reschedule as soon as possible. Failure to arrive for your previously scheduled appointment without **24 hour** notice will result in a $50.00 fee to you, not to your health insurer, for each appointment missed, which must be paid prior to the your next scheduled appointment. Three canceled appointments or failure to arrive without notice on two occasions within the same plan of care, will result in immediate discharge from physical therapy. _____ (***initial***)

You agree to assign all medical benefits to Maryland Physical Therapy for services provided. _____ (***initial***)

It is your responsibility to pay all co-payments, co-insurance, deductibles, or "cash pay" estimated amounts at the time of service. _____ (***initial***)

For any reason, if the your health insurance company does not pay for physical therapy services rendered by our office, you shall assume financial responsibility for the total amount owed. _____ (***initial***)

It is your responsibility to pay for unreimbursed services and balances within 30 days of receiving your invoice from Maryland Physical Therapy. _____ (***initial***)

Returned checks for invoice payments for services rendered by our office will result in a $40.00 service charge by our office. _____ (***initial***)

Failure to pay your invoice(s) for services rendered by our office within 30 days of receipt of invoices(s) at the mailing address you provided to our office will result in a late fee of $25.00. _____ (***initial***)

Any outstanding balance for services rendered by our office past 60 days from the receipt of invoice(s) at the mailing address you provided to our office will result in a collection fee of 30% of the unpaid balance and forwarded to Montague Collection Corporation. You will also be immediately discharged from physical therapy. _____ (***initial***).

If you have a previous balance for services rendered by our office and wish to receive additional services, you will be required to pay all previous balances prior to future services rendered. _____ (***initial***).

Last Name: _____ First Name: _____ MI: _____
Mailing Address: _____
Phone: _____ Home/Cell/Work (please circle which)
Email: _____
Emergency Contact: _____ Relation to Patient: _____
Emergency Contact's Phone Number: _____

Primary Health Insurance Company: _____
Insured Name: _____ Date of Birth: _____
Relationship: _____
Policy Number: _____ Group Number: _____

Secondary Health Insurance Company: _____
Insured Name: _____ Date of Birth: _____
Relationship: _____

Policy Number: _____ Group Number: _____

I authorize Maryland Physical Therapy to apply for benefits on my behalf for services rendered by Maryland Physical Therapy. I request payment from my health insurance company be made directly to Maryland Physical Therapy. I certify that the information I have provided with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at anytime in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

Copayment: _____

Coinsurance: _____

As of this date, Annual Deductible for Physical Therapy: _____

_____

I have read the above information and certify that I understand and will abide by the policies set forth by Maryland Physical Therapy by signing below.

Signature of Subscriber or Beneficiary: _____

Patient's Name (please print): _____

Patient/Authorized Representative Signature: _____

Date: _____

Witness Signature: _____