AXIS PT

Orthopedic, Manual and Sports
Physical Therapy

Welcome to AXIS PT. The following information is provided to give you a clearer understanding of AXIS' financial policy. If you need further clarification, please do not hesitate to ask our office manager for assistance.

Insurance Benefits

As a courtesy, AXIS will verify your insurance benefits prior to your appointment and will bill directly for services rendered. However, you may also want to verify your coverage to ensure that you are aware of any pre-certification and/or limitations your policy may include. The information obtained when AXIS verifies your coverage is not a guarantee of payment or a promise to pay from your insurance company and is not intended to release you from your financial responsibility. Initial: _____

It is AXIS' policy to collect payment within 30 days of the date of service. However, we will allow 60 days for your insurance company to process your claims. If your insurance carrier does not remit payment within 60 days, you will be billed for the full amount owed on your account. If your insurance carrier makes any payment in excess of the balance on your account, we will promptly refund you the credit. **Initial: _____**

Insurance Co-Payments and Deductibles

Any insurance co-payments or deductibles that you are responsible for will be due in full at the time of your appointment or at the end of each week that you have received treatment. Initial: _____

No-show/Cancellation Policy

There will be a charge of **$75.00** for any and all no shows and **$50.00** for late cancellation of appointments with less than 24-hour notification. **PLEASE CALL THE OFFICE TO CANCEL OR RESCHEDULE YOUR APPOINTMENT DO NOT EMAIL. Initial: _____**

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner I will be referred to a collection agency and/or attorney. I also understand and agree that I will be responsible for all costs of collecting money owed, including court costs, collection agency fees and attorney fees. **Initial: _____**

Patient Signature: _____

Date: _____

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