Body Wise Therapy, P.C.

2504 South 119th Street
Omaha, NE 68144-2975

Financial Policy

Thank you for choosing BodyWise Therapy as your health care provider. We are committed to providing quality Physical Therapy. In order to reduce potential confusion and misunderstandings, please read this agreement and sign prior to treatment.

_____ **ASSIGNMENT OF BENEFITS:** **(Please Initial)**

I hereby assign payment directly to the therapist(s) accepting this assignment of medical benefits applicable and otherwise payable to me but not to exceed the therapist's regular charges. I understand that I am financially responsible for charges not covered by this assignment or for any and all charges that the insurance carrier declines to pay. It is further agreed that any credit or balance resulting from payment of insurance or other sources may be applied to any other accounts owed to said therapist by the insured or his/her family.

_____ **RELEASE OF INFORMATION:** **(Please Initial)**

The therapist(s) may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the therapist(s) or to the patient or to a family member or employer of the patient for all or part of the therapist(s) charges, including but not limited to; insurance companies, worker's compensation carriers, welfare funds or the patient's employer.

_____ **FINANCIAL POLICY:** **(Please Initial)**

Insurance

Your insurance policy is a contract between you and your insurance company. We will need current and valid insurance information to accurately check your insurance plan with your insurance company. As a courtesy, we will file claims for those plans with which we have an agreement. If your insurance company does not pay within a reasonable amount of time, we will look to you for payment. All health plans are not the same, and they do not always cover the same services. In the event your health plan determines a service is "not covered" you will be responsible for the complete charge. This office is not responsible for disputing insurance company decisions regarding coverage. Payment is due upon receipt of a statement from our office. It is your responsibility to know your insurance benefits including, but not limited to, deductible and co-payment amounts that are contracted with your plan. It is also your responsibility to notify our office when your insurance plan or benefits change. Any costs incurred by this office because of incorrect information provided to us by you will be your responsibility.

If you have insurance coverage with a plan with which we do not participate or you have no health insurance plan, charges for your care and treatment are due at the time of service.

Co-Pay

Our insurance contracts require us to collect co-pays at the time of service.

Minors

A parent or legal guardian must accompany a minor patient on his or her first visit to our office so we can obtain a signature to treat the minor patient. A minor may be treated on subsequent visits without a parent or guardian if we have written permission from the parent or legal guardian. The adult accompanying the minor patient is responsible for payment of the services at the time of service.

Cancelled/Missed Appointments

We strive to provide the best possible service and availability for all of our patients. You will gain the maximum benefit from your treatment by consistently attended treatments as scheduled. Please help us serve you best by keeping your scheduled appointments or by calling as early as possible to reschedule or cancel. Repeated missed or cancelled appointments may require we discontinue your therapy until a time when you are able to consistently attend treatment.

I have read the Financial Policy. I understand and agree to the above Financial Policy.

X _____ _____

Signature Relationship to Patient if minor

X _____ _____

Witness Date

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