Financial Policy

Deductible $ _________ / $ __________ met

Co-pay/coinsurance ___________________

Out of pocket $ ________ / $ _________ met

Date Verified: _________________________

☐ N/A - no patient responsibility

Please carefully review our financial policies to answer any questions you may have regarding your services with us.

- All co-pays are due at the time of service.
- We accept cash, checks, Visa and Mastercard.
- Payment in full may be due at the time of service depending upon services rendered.

Insurance: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you we will bill your insurance provider for the services rendered. Your contract dictates the services that are covered and the amount of payment for those services. You are responsible for payment of services provided, a physician's referral and our verification of insurance does not guarantee payment. Please advise our clinic of any changes or updates in address, insurance, phone, new injury or employment changes to ensure accurate billing.

Medicare Patients: As of January 1,2006 Medicare has a dollar amount cap for outpatient Physical Therapy benefits. Your supplemental plan may provide coverage beyond this cap. It is your responsibility to be aware of the remaining benefits under Medicare. This waiver is an acknowledgement that you are aware of the Medicare cap and that you are responsible for paying the balance on any visits that Medicare or your insurance does not.

Workers Compensation Claims/Self-Insured Claims: Please provide the office the name and phone number of your claims representative before you begin treatment. We request your private insurance information at the time of service. If your L&I claim is not accepted we will bill your private insurance. You are responsible for payment of services rendered if your claim is not accepted.

Motor Vehicle Collisions: We will bill your Personal Injury Protection Insurance (PIP) as a courtesy to you. However, you are fully responsible for the bill. In the event that payment has not been made within 30 days, you will be required to make payment arrangements.

Private Pay/No Insurance: Full payment is due at the time of service.

Doctor Referrals: You are responsible for obtaining a referral and/or prescriptions from your primary care physician prior to your appointment. It is your responsibility to make sure we have a valid and current copy of your referral/prescription in the office at the time of your appointment. Exceptions to this policy are plans that have direct access to therapy with no referral required.

Payment Issues: Please contact our Billing department as soon as possible if financial problems arise. If an account becomes past due, necessary action will be taken, up to and including collections or legal action. The undersigned understands that he/she or his/her agent is responsible for charges incurred.

Cancellations and No Show appointments: If you are unable to make your scheduled appointment we ask that you contact our office to cancel your appointment. If appointments are cancelled with less than 48 hour notice there is a $45 cancellation fee that will be the patient's responsibility.

_____ *Initial*

I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that the benefits quoted to me are not a guarantee of claim payment. I understand that payment is dependent on my eligibility at the time of service and ALL terms and conditions of my insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges.

_____ *Initial*

I authorize Capstone Physical Therapy to release any necessary information requested by my insurance carrier and authorize payment directly to Capstone Physical Therapy for any benefits available under my insurance plan. I have read and understand the above mentioned and consent to evaluation and treatment. I have carefully read the Financial Policy and agree to the terms therein.

Signature of Patient or Responsible Party	*Print Name*	*Date*