

IT IS IMPORTANT THAT YOU UNDERSTAND THAT YOU ARE PERSONALLY RESPONSIBLE FOR ALL SERVICES RENDERED AND THAT ALL FEES ARE CHARGED DIRECTLY TO YOU. AS A COURTESY, WE WILL BILL YOUR INSURANCE IF YOU PROVIDE US WITH THE APPROPRIATE INFORMATION. THIS DOES NOT RELEASE YOU FROM ULTIMATE RESPONSIBILITY FOR PAYMENT OF OUR SERVICES.

**Health/ Accident Insurance:**

We will be happy to bill your insurance company, but because of increasing complexity of all health care programs you should contact your insurance company to establish what your benefits are for physical therapy, whether or not you need prior authorization and if you have a co-payment. All co-payments are due at time of service.

**Worker's Compensation:**

Bills are submitted to your employer's insurance carrier. Your employer's name, address, and claim or file number is required before or no later than your first visit. It is the patient's responsibility to inform us who the claims adjustor is and to supply us with a copy of the incident report.

**Motor Vehicle Accidents:**

If you have medical coverage (med-pay) on your auto insurance policy, we will bill them for prompt and direct payment for your care. We require a signed lien on all motor vehicle accidents if an attorney is involved with your settlement. If you are going through a third party auto insurance and they don't pay within 30 days you will be responsible for 20% of the monthly balance until your bill is paid completely or you receive your settlement in which you will pay the remaining balance of your bill immediately.

**Attorney Lien:**

If you wish to hold your balance on a lien, we require that you sign a lien form and supply the name, address, and phone number of your attorney. We will mail your signed lien to your attorney for his/her signature. If at any time your attorney becomes uncooperative, we reserve the right to withdraw all lien privileges and demand payment in full.

**Medicare:**

You are responsible for a 20% share of cost and any deductible or non-covered charges. Medicare pays 80% and your secondary insurance will pay the 20%.

**No Show Policy/Late Policy:**

If you are unable to keep an appointment, please call to reschedule. Failure to cancel your appointment within 24 hours of the schedule time will result in a \$25.00 fee charged directly to you. If you show up for your appointment 15 minutes late that may result in re-scheduling your appointment to another day. If you miss your appointment that will also result in a \$25.00 fee.

**Appointment Information:**

Your appointments will be anywhere from 30 minutes to 1 hour.

I hereby authorize payment of medical benefits to Professional Orthopedic & Sports Care (P.O.S.C.). I allow release of medical information necessary to process the claim and consent to receiving physical therapy treatments. I have read, understand and agree to the above stated financial policies. (Copies available on request)

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I have read the Notice of Privacy Practices letter given to me and understand that Profession Orthopedic & Sports Care is compliant.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_