

ADVANCED SPINE PHYSICAL THERAPY HIGH DEDUCTIBLE FINANCIAL POLICY

Welcome to Advanced Spine Physical Therapy. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. In order for our relationship to be mutually satisfying and beneficial, we encourage you to discuss with us promptly and openly any concerns about your treatment, services or fees. Any misunderstandings and lack of communication can only lead to dissatisfaction.

Our patients can expect:

- High degree of professional skill and ability
- Fees that are customary for our area

In return we expect:

- Cooperation in making and keeping appointments
- Your payment of fees (for which you are personally responsible) at the time of service
- Your assistance in keeping us informed of your current health insurance information

Method of payment

1. We accept cash, check* or credit card (Visa, MasterCard or Discover)
2. Insurance. We will bill your primary insurance as a courtesy to you.

*A fee of \$25.00 will be charged on all returned checks.

It is considered appropriate for a patient to pay the portion of their medical expenses for which they are responsible at the time of service. The balance of the expenses is then submitted to the insurance company. In good faith Advanced Spine Physical Therapy has verified your benefits and insurance coverage. We have been informed that you have a _____ deductible which has/has not been met and a payment of _____ is required at each visit. **These payments will be applied to your deductible. Until your deductible is met, your insurance will not pay any claims.** When we receive the explanation of benefits from your insurance, adjustments might need to be made. In the event there is an outstanding balance due, payment is required on receipt of the statement. Your insurance company cannot be billed unless you give us complete insurance information along with a copy of your insurance card. Your insurance policy is a contract between your insurance company and yourself; we are not a party to that contract.

Patient's initials _____ ASPT initials _____.

Advanced Spine Physical Therapy is committed to providing the best treatment for our patients, and charges are what are considered usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. **If your insurance company has not paid your account in full within 60 days, from your last visit, the balance will be automatically transferred to your account for payment. Outstanding patient balances due over 90 days will be charged interest at a rate of 2% per month.** Please be aware that some services may be non-covered services and not considered reasonable and necessary under the Medicare and/or other medical insurance.

Minor Patients

Minors under the age of 18 needs to be accompanied at their first visit by the parent or guardian to sign patient information and financial responsibility forms. The parent or guardian is responsible for full payment.

Cancellations and Missed Appointments

If needed, please cancel your appointment at least **24 hours** in advance. Appointments not canceled 24 hours prior to scheduled time will be charged a fee of \$50.00

Collections

In the event a patient's account is delinquent or a patient fails to abide by these financial terms, the account will be handed over for collection and the responsible party will be liable for any collection fees, attorney fees and court costs.

Financial Agreement

I hereby authorize direct payment of medical benefits to Advanced Spine Physical Therapy. I have read and understood the above financial policy, **and agree to be responsible for any outstanding balances not covered by my insurance.** My signature below authorizes the office to release medical information to my insurance company only to assist with any outstanding balances on my account. Patient's initials _____.

PRINT NAME

SIGNATURE OF PATIENT OR GUARDIAN

DATE