ADVANCED SPINE PHYSICAL THERAPY

MEDICARE 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. If you do not have secondary insurance, you will be responsible for the portion of the allowed fees not paid by Medicare. This will be approximately $20 per visit and is required at each visit. When we receive the EOB from Medicare, adjustments might need to be made. In the event there is an outstanding balance due, payment is required on receipt of the statement.

Medicare recommends you start your Physical Therapy within a timely manner from your doctor's visit. If continuing treatment is deemed medically necessary after 90 days a re-certification is required.

As of the 1st of January 2009, Medicare has implemented an annual capitation of $1,840 for Physical Therapy and Speech Therapy combined. It is your responsibility to inform us of any Physical Therapy or Speech Therapy that you have received in 2009. Please check the box (es) for any of the clinical services that you may have received this year:

_ Speech Therapy _ Dr. of Osteopathy _ Chiropractor _ Home Health Physical Therapy

You can call Medicare on 1-800-633-4227 to verify your benefits status.

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.

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___________.

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SIGNATURE OF PATIENT OR GUARDIAN DATE