Payment Policy

Thank you for choosing us as your Physical Medicine point of care. We are committed to providing you with quality and affordable health care. Because some of our patients have questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Self-Pay: If you are without insurance coverage or are not insured by a plan we do business with, your discounted payment in full is expected at each visit.

Insurance: We are currently pending contracts with some commercial insurance companies. Our goal is to participate in most insurance plans. If you are insured by a plan we are contracted with we will as a courtesy submit a claim for your visit. If you do not have an up-to-date insurance card, and benefits and eligibility cannot be verified – payment is required in full for each visit until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments and Deductibles: All co-payments and deductibles and coinsurance must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles and coinsurance from patients can be considered fraud. Please help us in upholding the law by paying your responsible portions at each visit.

Non-covered Services: Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You are responsible and must pay for these services in full.

Proof of Insurance: All patients must complete our patient information form before being seen for your treatment. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the full balance of a claim.

Claims Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative care. During that 30-day period, our facility will only be able to treat you on an emergency basis.

Missed Appointments: Our policy is to charge for missed appointments not canceled within a reasonable amount of time, (24 hours prior). These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date:**

_____ _____

Facility Witness: **Date:**