PINTI PHYSICAL THERAPY

Financial Policy

(Effective 02/15/2011)

- ALL Co-Payments are due at each visit.
- We will bill primary and secondary insurances only. We will bill any coverage required by federal or state law.
- If you have a deductible, that has not been met, we will require you to pay $50 each visit.
- Insurance balances not paid within 60 days will be billed to the responsible party.
- Patient billed amounts that reach 90 days without a payment posted to the account will be sent a pre-collection notice. If there is no response after the 4th billing cycle, the account will be processed for further collection procedures.
- If your insurance carrier requires a co-insurance fee, we will strongly encourage you to pay an estimate of your co-insurance for each visit according to the following rate: 10% = $10 payment, 20% = $20 payment, 30% = $30 payment, and so on. This is only an estimate of your financial obligation to us and you may still receive a bill if there is a balance due to us once your insurance pays its portion.
- Appointments must be cancelled at least 24 hours in advance. No show appointments without valid reason will be billed a $35 office visit fee.

STATEMENT OF UNDERSTANDING AND AGREEMENT OF TERMS

I have read and understand the Financial Policy. I agree to the terms of this policy.

_____

Patient / Parent or Guardian Date

********** For Office Use Only **********

Patient Name : _____

Our office has contacted your insurance company to verify benefits for outpatient physical therapy treatment. The following information received from your insurance company only clarifies your contract; it is NOT a guarantee of payment.

Your effective date of coverage is: _____ /_____ /_____

You are responsible for a $_____ deductible. At this time $_____ has not been met.

Your payment each visit will be $_____.

After this deductible has been met, your insurance will pay at _____% and you are responsible for _____%.

There is a limit of _____ visits per calendar year. As of this date, you have used _____ visits.

Your co-payment due each visit is $_____.

_____

Patient Signature Date