

THANK YOU FOR CHOOSING PHYSICAL THERAPY ADVANTAGE, PC. We are committed to providing the very best care possible. In order to keep your cost of healthcare services to an absolute minimum we require you to read and sign this Financial Policy before any services are rendered.

PPO/POS/Other Managed Care Contracts, In-Network: Co-pay and co-insurance amounts are due at the time of service. Deductibles, if applicable, will be billed to you once we receive notice from your insurance company.

Managed Care Contracts, Out-of-Network: You are responsible for your portion of co-insurance at the time of service. Deductibles and any adjustments will be billed to you once we receive notice from your insurance company.

Medicare Patients: As a participating member with Medicare we accept assignment for services provided to you. You are responsible for any deductible and co-insurance applied.

Workers' Compensation: According to the laws in the State of Illinois, Worker's Compensation carriers are not required to pay claims at 100% of billed charges. Balances not covered by Worker's Compensation carriers are the responsibility of the patient. We will file a claim with your employer or its insurance company as long as we have verification that your injury is being considered a compensable Worker's Compensation claim.

Motor Vehicle Accidents/Third Party Liability: Full payment is required at time of service. As a courtesy to our patients, we will forward all claims to your insurance company and they will reimburse you directly. You are responsible for all charges incurred during your treatment regardless of any claim or pending legal action. *We do not file claims with any other involved party's insurance.*

Secondary/Supplemental Insurance: We Do Not provide billing services for secondary or supplemental insurance carriers. If you have coverage it is your responsibility to secure reimbursement. Any expected co-insurance your primary insurance does not cover will be collected at each visit. In some cases Medicare will automatically forward claims to your supplemental insurance – if this occurs you do not need to submit the claim yourself.

Referrals: We try our best to keep track of your number of visits allowed on each referral and also of referral expiration dates. If you also keep track it would be a great help. If you should need a new referral/prescription to continue therapy or if your next visit with your doctor is approaching, please let your therapist know so that he/she can write a progress note to your doctor. We will write the note and send it but it is your responsibility to get the new referral/prescription. If there is any question about whether or not your doctor will issue a new referral/prescription, please call their office.

Account Statements & Late Fees: Every effort is made to avoid the cost of mailing statements. At your request we will supply a copy of your account for you. If not paid during time of treatment your responsibility of any open balance is due in full upon receipt of your account statement. Unpaid balances older than 90 days will be charged 18% annual interest.

Supply Charges (including electrodes): Payment is due in full when we provide a supply item. If your insurance company considers supply charges they will be billed and we will reimburse you for any portion covered by your insurance.

Payment Agreement: I hereby assume full responsibility for and agree to pay all costs, charges, and expenses incurred by the patient, to Physical Therapy Advantage. I understand and agree that this understanding constitutes a direct primary and personal undertaking by me and is not conditioned or contingent upon payment of any such costs, charges or expenses by any third party. The assignment of benefits of any insurance policy or medical reimbursement plan shall not be deemed waiver of the Provider's right to require payment directly from the undersigned. The Provider expressly reserves its right to require such payment. In the event that this obligation remains unpaid and requires referral for collection, the undersigned agrees to pay all costs of collection, including, but not limited to reasonable attorney's fees. If the undersigned is more than one person every obligation hereunder shall be joint and several.

All patient payment responsibilities are due at the time of service. We accept cash, check, Visa and MasterCard. Our charges are usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates, unless we have a participating agreement with that company.

I understand and agree to the above statements.

(Signature of Responsible Party)

_____/_____/_____
Date

(Witness)

_____/_____/_____
Date

My method of payment will be: (please check)

Cash or check at time of visit (**Co-pays are appreciated at time of visit**)

Credit Card (Visa/MasterCard)

Pay at time of visit

Send me statement and call to authorize payment

Keep my card on file and charge as needed (Please ask for our Credit Card Authorization Form)

The information below has been provided by your insurance carrier and is not a guarantee of benefits until payments are received.

We contacted _____ to confirm your insurance benefits for physical therapy.

Deductible: \$ _____ Met?: _____

Co-Insurance (**This is your responsibility, due each visit**): _____ Co-Pay (**This is your responsibility, due each visit**): _____

Limitations: _____ OOP Maximums: _____