

Premiere Physical Therapy

Financial Policy

We are dedicated to providing excellent medical care to all of our patients. This document is designed to provide you with the information regarding your responsibility in the billing process. Please take a few moments to read the following:

Patient responsibility:

- You are ultimately financially responsible for the medical services you receive. We bill your insurance, and it is your responsibility to provide us with accurate and up to date insurance information.
- You are responsible to know your insurance benefits, including coverage for physical therapy and injections. Please refer to the number listed on your insurance card to verify benefits. If you need clarification of your benefits; our billing department will be happy to answer any questions you may have pertaining to your benefits.
- If you do not have insurance coverage on the date of service, the entire cost becomes your immediate responsibility.
- You are responsible for all denied charges, non-covered services, the annual deductible, coinsurance and co-payments.
- Failure of your insurance carrier to pay within 90 days of filing is viewed as a refusal to pay, and you may become financially responsible.
- CO-PAYS ARE TO BE PAID AT THE TIME OF SERVICE. CO-PAYS ARE DUE AT EVERY VISIT INCLUDING PHYSICAL THERAPY.
- We require a minimum of 10% of any unpaid balance to be paid monthly.
- If you have a deductible that has not been met, we will collect a portion of your office visit towards this at the time of service. Physical therapy deductibles can be paid in allotments of \$75 for each visit until the deductible has been met.
- Authorizations must be present prior to your appointment.

Returned Checks:

Checks returned due to insufficient funds will be assessed an additional \$25 processing fee for the first occurrence.

Our focus is always on medical issues rather than financial issues. We appreciate your assistance with this matter and your continued patronage.

Your signature indicates that you have read and understand our financial policy and agree to abide by it.

Signature: _____ Date: _____

Witness' Signature: _____ Date: _____