

Richmond/Ashland Physical Therapy

RICHMOND/ASHLAND PHYSICAL THERAPY FINANCIAL POLICY

Thank you for choosing Richmond/Ashland Physical Therapy for your rehabilitation needs. 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 any treatment. All patients must complete this information before seeing the provider.

Regarding Insurance

We may accept assignment of insurance benefits. However, **we do require that all co-payments be made at time of service.** The balance is your responsibility whether or not your insurance pays or not. We cannot bill your insurance company unless you give us your current insurance information. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You will be responsible for these balances. Should your insurance coverage change while you are still receiving care it is your responsibility to provide us with this new insurance information. We will not be able to submit claims without this information.

Initial _____

I understand that it is **my own responsibility to understand my insurance coverage** as it relates to the services I am about to receive. I understand that my insurance company has provided a toll-free phone number on my insurance card that I can call at any time to ask any questions regarding coverage, eligibility, exclusions, deductibles, co-pays, or any other inquiry I may have. I understand that Richmond/Ashland Physical Therapy in no way has any power to dictate policy or procedure of my own insurance company.

Initial _____

I understand that **my own insurance company decides** what to reimburse Richmond/Ashland Physical Therapy only after bills are submitted and reviewed. Richmond/Ashland has no authority or ability to decide what treatments will/will not be paid nor at what price. Only my insurance company knows this information once bills are submitted.

Initial _____

Returned Checks

There will be a \$25.00 returned check fee on all returned checks.

Initial _____

Collection Fees

In the event that your account is turned over to a collection agency, you will be responsible for all collection costs including reasonable attorney's fees.

Initial _____

ASSIGNMENT OF BENEFITS

I have read and agree with the above policies. I hereby authorize my insurance benefits to be paid directly to RICHMOND/ASHLAND PHYSICAL THERAPY. I also authorize RICHMOND/ASHLAND PHYSICAL THERAPY to release any necessary information to process this claim.

Signature

Date