

## PATIENT FINANCIAL POLICY

This is an agreement between Physical Therapy Center of Ocean Springs (creditor) and the Patient (debtor) named on this form.

*In this agreement the words "you", "your", and "yours" means the Patient (debtor). The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us", and "our" refer to Physical Therapy Center of Ocean Springs.*

By executing this agreement, you are agreeing to pay for all services and supplies that are received.

**Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. It will show separately that previous balance, any new charges to the account, any new payments or credits applied to your account during the month. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

**Required Payments:** Any copayments or coinsurance required by an insurance company must be paid at the time of service. We shall have the right to cancel your privilege to make charges against your account at any time and require that visits must be paid at the time of service.

**Contracted Insurance:** If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay, deductible, or co-insurance, you must pay at the time of service. As contracted providers with your insurance company, we agree to accept the allowable amount (usual and customary) established by your insurance company. Although we may estimate what your insurance company may pay and the patient responsibility portion, it is the insurance company that makes the final determination of payment and eligibility.

**Non-Contracted Insurance:** Insurance is a contract between you and your insurance company. It is the patient's responsibility to verify if our office is a contracted provider or non-contracted provider. As a non-contracted provider, there is no adjustment or write-off for the difference between what we charge and what the insurance allows. You agree to pay any portion of the charges not covered by your insurance.

**Primary Insurance:** If possible, we will verify your insurance benefits and eligibility during your first appointment. It is the patient's responsibility to be aware of your own benefits and eligibility. As a courtesy to you, we will bill your primary insurance; however, if our office has not received payment after 120 days, the balance will become patient responsibility unless other arrangements are made with us.

**Secondary Insurance:** As a courtesy to you, we will bill your secondary insurance after your primary insurance has paid. If our office has not received payment from your secondary insurance after 120 days from the date first billed to your secondary insurance, the balance will become patient responsibility unless other arrangements are made.

**Referrals/Prescriptions/Authorizations:** If your insurance company requires a referral, prescription, or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral, prescription and/or preauthorization may result in a lower payment, or no payment from the insurance company.

**Workers Compensation:** We require approval/authorization by your worker's compensation carrier prior to your initial visit. We will obtain this as a courtesy for you. We will also obtain approval/authorization for your follow up appointments. It is your responsibility to provide us with accurate information in order to contact your carrier.

**Personal Injury/ Motor Vehicle Accidents (MVA):** If you are being treated as part of a personal injury lawsuit or claim, we may require verification from your attorney. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges, we may consider accepting a letter of protection. If you have Personal Injury Protection/Medical Payment through your motor vehicle insurance, we will bill them as primary insurance and will bill your private health when your vehicle insurance exhaust.

**CONT. PAGE 2 please turn over**

**CONT. PAGE 2 please turn over**

**Benefit Assignment:** You assign all medical benefits to us including health insurance, Medicare, auto insurance, worker's compensation, or other insurance plans. You also authorize Physical Therapy Center of Ocean Springs to release all information necessary (including photocopies of medical records) to secure payment (see Notice of Privacy Practices). You agree that if insurance pays directly to you, this monetary amount is actually due and is patient responsibility.

**Billing Information:** It is your responsibility to provide us with correct information including insurance, responsible party, date of injury, type of accident, policy and /or group numbers, etc. Should the information change, it is your responsibility to update it within a timely manner. If you supply us with incorrect information, the balance will be your responsibility. We will not be responsible for rebilling, appealing or other dealings with newly provided insurance information.

**Medicare:** We are a participating Medicare Part B provider. We will bill Medicare and your supplemental carrier (if applicable). Physical Therapy services can only be performed on a Medicare patient that has been seen by their referring physician every 90 days. This means that you must follow up with your physician every 90 days for Medicare benefits to apply. Medicare does not pay for supplies or durable medical equipment provided by Physical Therapist. In the event it is required to issue you a supply, you will be asked at that time to sign a Medicare Waiver Statement and pay for the supply. You will also be informed of the Medicare Cap Limits for Physical Therapy on a separate sheet.

**Methods of Payment:** We accept Visa, MasterCard, Discover, personal checks and cash. We do not carry change. If paying cash, it must be the exact amount. There is a fee of \$25.00 for any check returned by your bank.

I have been informed of my financial responsibility and agree to the terms and conditions as stated on this form.

**Patient Name:** \_\_\_\_\_

**Responsible Party (if patient is a minor):**  
\_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_