



INSURANCE POLICY

It is our goal to provide you with the most efficient care possible. Should you have any questions regarding your insurance coverage or payment policy, please feel free to discuss this with our administrative staff.

Advance Physical Therapy, Inc. has several contracts with insurance companies. As a contracted provider, Advance Physical Therapy, Inc. will accept the contracted rate as determined by the insurance entity but patients are solely responsible for any and all co-payments, deductibles, co-insurance (percentage of the allowed charges), and "non-covered" services that the insurance company may not authorize.

For insurance entities that Advance Physical Therapy, Inc. is not contracted with, patients will be responsible for any and all charges that the insurance company does not cover as payment.

Please note that insurance coverage is considered a method of reimbursing the patient for charges paid to the treating clinic or physical therapist and is not a substitute for payment. You are responsible for 100% of all charges incurred; your physician referral prescription and insurance coverage verification is not a guarantee of payment.

PAYMENT POLICY

Full payment of co-payments, deductibles, co-insurance and self-payments are due at the time of service. Payment of durable medical equipment (DME) is due at time of purchase during the physical therapy visit. Advance Physical Therapy, Inc. will assess a finance charge of 1.5% on all accounts overdue. There will be a NSF fee of \$25.00 assessed for every returned or bounced check. I understand if my account should become delinquent I will be responsible for all reasonable collection costs and attorney fees.

Initial: _____ Date: _____

APPOINTMENT AND CANCELLATION POLICY

If you are unable to keep your scheduled appointment, please notify our office at least 24 hours in advance prior to your scheduled appointment time. If we do not receive notice of your cancellation within 24 hours, your account will be assessed a \$100 cancellation fee for the office visit. I understand if my account should become delinquent I will be responsible for all reasonable collection costs and attorney fees.

Initial: _____ Date: _____

CONSENT FOR CARE AND TREATMENT

I authorize and give my consent for treatment to Advance Physical Therapy, Inc. I understand that I am financially responsible for any balance on my account. I also authorize Advance Physical Therapy, Inc. to release any medical information required to process my claims and to receive payment.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____