Policies and Procedures

Thank you for choosing us as your physical therapy provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. A copy will be provided to you upon request.

- Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan, we do business with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
- Co-payments, coinsurance, and deductibles. All co-payments, coinsurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, coinsurance and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment or coinsurance and deductibles at each visit. We would also be happy to set up a monthly payment plan should you need to.
- Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.
- Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
- Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. It is your responsibility to advise us if your insurance changes prior to your next visit.
- Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to collections.

 Forms of Payment Accepted: (Cash, Check, Visa, MasterCard, Discover)

 Returned checks will be subject to a Non-Sufficient Fund fee of $25

- Services are non-refundable. All Self Pay services are non-refundable. In addition, once a visit has been sent to insurance or self-pay was used for a visit at Optimal Physical Therapy we cannot rebill. By signing this form, you are acknowledging that you understand the policy and no rebilling or refunds will be processed for any self-pay services.
- Credit card on file policy. At Optimal Physical Therapy, we require keeping a credit or debit card on file as a means of convenient payment for patients and to protect our time as a medical provider. We can assure you that your information will be held securely until your insurances have paid their portion and notified us of the amount of your share. Your credit card will only be charged if you have an outstanding balance and is past 60 days due OR have an outstanding No Show/ Late Cancel fee. Insurance balances will be charged every first Tuesday of the month and No Show/ Late Cancel fees will be charged on the date of service missed. Any patient with a balance of $100.00 or more will be contacted by phone to confirm the charge. Instead of receiving an invoice in the mail monthly, you will receive a copy of the charge and receipt. Patients with a verified Worker's Compensation or Automobile Insurance claim are exempt from having a credit card on file. If you have any questions about this new policy, do not hesitate to ask.

I have read these policies and by signing below I am indicating that I understand these policies.

_____ _____

Patient Signature Date