

mattsmith

PHYSICAL THERAPY

www.mattsmithpt.com

FINANCIAL POLICY & ASSIGNMENT OF BENEFITS

All fees for medical care are based on the usual, reasonable and customary fee charged in this area by physical therapists of equal training and experience.

PAYMENT FOR MEDICAL SERVICES RENDERED ARE DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE. **You will be expected to pay your insurance co-payment at each visit.** There will be a \$25 service charge for any checks returned to our office.

Our office will make every effort to verify eligibility and benefits with your health insurance company. **The amount quoted to us over the telephone is NOT a guarantee of payment nor determination of benefits. It is an estimated amount that you are responsible for. It is ultimately your responsibility to know the type of insurance plan/policy you are enrolled in and whether or not we are contracted providers.** The exception is for those patients with work-related claims covered by Worker's Compensation. These patients are not responsible for their bills unless their claim has been denied.

Having read the above, I hereby authorize payment by my insurance carrier or other designated payor of medical benefits to MATT SMITH PHYSICAL THERAPY for services furnished to me. This assignment will remain in effect until revoked by me in writing. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. I understand that MATT SMITH PHYSICAL THERAPY requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the business manager. **I further understand and agree that if the account is not paid within 90 days of the last date of service and no financial arrangements have been made, I will be personally responsible for any and all expenses incurred in the pursuit of collection of my account including any and all attorney's fees, filing fees, including charges or commissions that may be assessed by any collection agency retained to pursue this matter and interest at the legal rate plus 2% over prime.**

I also authorize MATT SMITH PHYSICAL THERAPY to release to my insurance carrier or their agents any medical information about me needed to determine these benefits or the benefits payable for service.

PATIENT'S OR RESPONSIBLE PARTY'S SIGNATURE

DATE

PATIENT'S OR RESPONSIBLE PARTY'S PRINTED NAME

