Performance
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FINANCIAL POLICY

PATIENT'S NAME: _____ **DOB:** _____ /_____ /_____

THANK YOU FOR CHOOSING PERFORMANCE THERAPIES, PC! We are committed to your entire experience here being successful. As you have a financial responsibility to ensure full payment of your bill, all patients are required to complete this financial policy prior to being seen by a physical therapist and to update this information annually.

PATIENT LIABILITY It is the patient's responsibility to know their insurance policy's "Schedule of Benefits" and level of coverage. As physical therapy providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are strictly your responsibility. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered by your policy. As part of your insurance contract, you are required to pay co-pays at the time of service.

WORKER'S COMPENSATION As physical therapy providers, our relationship is with you, not your worker's compensation provider. It is the patient's responsibility to have established their workers compensation claim and verify that physical therapy is authorized. We will confirm the authorization with your worker's compensation carrier. You must provide us with a copy of your personal insurance card and a current authorized form for physical therapy signed by your physician. In the event payment for your claim is denied by your worker's compensation carrier, we will file the claims with your personal insurance policy. If your claim is denied by your personal insurance, you are responsible for the full payment of your bill.

PERSONAL INJURY, LIABILITY, AUTO, OR INVOLVEMENT OF AN ATTORNEY You must still provide us a copy of your personal insurance card. We may also need a physician's written referral for these cases, it is the patient's responsibility to have a referral if required. In the event your claims are denied by the liability carrier or that the personal injury protection benefits are exhausted, we will file claims with your personal health insurance policy. If your personal insurance policy denies the claim for any reason, you are responsible for the full payment of your bill. We do not accept an attorney 'letter of protection' for claims being disputed or in litigation and payment will be collected at time .

VISIT LIMITS During the course of your treatment if you approach a visit limit that requires authorization or medical review by your insurance company, please be aware that if your visits are not covered by your insurance carrier you will be financially responsible for payment of those visits.

INSURANCE INFORMATION We need complete and accurate information about your policy. The patient is re- sponsible for providing that information and to inform us of changes to insurance coverage during the course of treatment. Failure to do so may result in denial of coverage by your insurance company.

NON-INSURANCE-FEE-FOR-SERVICE This option is exclusively a non-insurance financial arrangement and is separate from the insurance scenarios. Fee-for-service receipts cannot be submitted to insurance for reimbursement. Performance Therapies, PC will reduce our standard insurance fee schedule to $125 for each evaluation and $90 for each follow up visit for this arrangement. To be eligible for this discount, full payment must be received for the services rendered at the time of service.

NO SHOW POLICY Broken appointments represent a cost to us, to you and to other patients. They also prevent patients who need to be seen from scheduling during that time. If you 'no-show' more than two appointments, you will be charged a $25.00 fee for each subsequent 'no show'. This fee is not billable to insurance and will be collected at the next appointment. We understand that there are special and unforeseen situations, and we will take those into account. Chronic missed appointments can result in denial of further treatment.

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COLLECTIONS We will work with you to avoid sending your account to collections. In the event of default on your account, your account will be turned over to a collection agency. You will be responsible for the unpaid balance and any additional collection related finance charges due to your unpaid balance. Accounts that are turned over to collections can result in denial of further treatment.

MEDICARE Performance Therapies, PC is a Medicare-approved provider of outpatient physical therapy. All Medicare policy holders need to have a physician's referral or prescription prior to starting as a physical therapy patient at Performance Therapies, PC. You will also need a physician's referral or prescription prior to returning to our office if 90 days has passed since your last treatment or if you have a new issue to be treated. It is our responsibility to be sure that the plan of care is certified by the referring physician and recertified according to Medicare guidelines, this may require you to follow-up with your physician more frequently. All coverage is subject to Medicare guidelines and regulations for out-patient physical therapy.

MINORS A parent or legal guardian must accompany the minor patient at the time of the initial visit. If the parents are separated and both legally responsible for the child, you must provide complete information from both parents. The parent or legal guardian that accompanies the minor patient to the clinic will have full responsibility of payment at outlined in the above financial policy should any dispute arise. At any follow up appointments where the parent or legal guardian does not attend, the copay will still need to be collected.

UNCOVERED SERVICES Throughout the course of your treatment you may need a brace or other therapeutic supplies recommended by your physician or physical therapist. Performance Therapies, PC is not a DME provider therefore if you need a brace, we will direct you to a DME provider that can help you order your brace. If you choose to purchase supplies through Performance Therapies, PC, payment will be collected at the time of purchase, and we will not be able to submit to your insurance carrier.

The patient is ultimately responsible for all fees for service. I have read, understood, and agreed to the above financial policy for payments of professional services.

HIPPA-PRIVACY PRACTICES

I, _____ , have read through the Notice of Privacy Practices from Performance Therapies, P.C.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent and authorize Performance Therapies, P.C., its agents, associates, and employees, to provide care and treatments to me per program policy and/or as prescribed by my physician. A representative of Performance Therapies, PC, will explain my plan of care and answer my questions I understand that the care plan my change and, if so these changes will be discussed with me. I agree to notify Performance Therapies, PC, my physician or others providing care of any adverse reactions or other significant events relating to my health. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment of my condition by Performance Therapies PC, its agents associates and employees. I understand and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to the patient/guarantor.

Signature: _____

Date: _____

For a copy of our policies please visit our website PTforHealth.com