IDEAL MOTION PHYSICAL THERAPY
FINANCIAL POLICY

1. If you wish for IDEAL MOTION PHYSICAL THERAPY to bill your insurance company, provide our office with a copy of your insurance card and any additional information to file the claim. If you do not have an insurance card, it is your responsibility to contact your insurance company or your employers Human Resources department to obtain all the necessary information to file a claim for you.

2. If you have insurance, IDEAL MOTION PHYSICAL THERAPY will bill your insurance company as a courtesy to you. If your insurance company does not pay the claim within 90 days of the date of service, you may be billed for the full amount. We will make every effort to contact your insurance company to find out the status of your claim and make any necessary corrections to have the claim paid within a reasonable amount of time. Please understand the ultimate responsibility for payment is yours, the patient. Should your insurance company deny payment or only cover a portion of the claim, the balance on your account will be your responsibility. You are responsible for payment of co-pay at the time of service. If you have not met your deductible, you will be responsible for paying the remaining amount left on your deductible in addition to your co-pay. **_____ Patient Initials**

3. If you are covered by Medicaid, you must present a Medicaid sticker or card at the beginning of each month. If you do not have your sticker or card with you, we may have to reschedule your appointment. You do not have co-pays for your visits.

4. If you have Auto Insurance, we will bill the FIRST PARTY coverage only, if you have a THIRD PARTY Claim, you will be responsible for your entire bill. Please make arrangements to pay for your visit each session. Please provide IDEAL MOTION PHYSICAL THERAPY with the name of your auto insurance company, address, phone number, claim number and date of injury, if you have health insurance we will also be happy to file your claims for you.

5. If you are under Workman's Compensation, it is your responsibility to provide IDEAL MOTION PHYSICAL THERAPY with the name of the insurance company, the date of injury, insurance company's mailing address, insurance company's phone number and your adjuster's name and your claim #. Without this information we will be unable to file your visit/claim with the insurance company. Make sure you have also notified your carrier you are being seen today.

6. A $50.00 No Show / Late Cancellation fee will be assessed if you do not notify our office within 24hours of your set appointment time. This fee is the patients' responsibility and must be paid before the next date of service**.** **_____ Patient Initials**

7. There is a $25.00 NSF charge for returned checks. **_____ Patient Initials**

8. **WE ARE NOT contracted with ASEA, GEHA or any Union Insurances, please be aware you will be responsible for any penalties associated with these insurance companies.**

9. You are responsible for the payment of any supplies or orthotics purchased. We will not bill your insurance company for the payment of any supplies or orthotics. All supplies must be paid for at the time of service. For patients that have Workman's Compensation, a receipt will be provided for submission. If you are a Medicare patient, you must sign an Advance Beneficiary Notice of Non-coverage form at the time of purchase.

10. Any patient overpayments/refunds will be processed quarterly after the final insurance payment has been processed and the final balance has been determined in order to close the patient's financial statement

If you have a balance on your account and need to make payment arrangements, please contact our office immediately to do so. An Interest rate of .875% will be assessed after 30 days on any remaining account balance. All delinquent accounts may be turned over to Cornerstone Credit Service for collection if a payment plan is not in place. By signing this form you have read and understand if your insurance does not cover your bill you will be responsible.

Patient's Name (PLEASE PRINT): _____

Patient's Signature: _____ Date_____

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