FINANCIAL POLICY

PAYMENT IS DUE WHEN SERVICES ARE RENDERED. Please read our financial policy carefully. If you have any questions about this policy, our staff will be glad to assist you.

PAYMENT PROCEDURE: (Please check the manner in which you will be paying)

( ) GROUP HEALTH INSURANCE:
We will file your claims to your insurance company and verify your benefits. We will inform you of any deductible, coinsurance or copayment amounts as quoted by your insurance. We require that you pay any deductible, copayment or coinsurance at the time of treatment. Benefits are subject to final approval by your insurance company; therefore, the amount is subject to change. **We file primary insurance as a courtesy; however if you have secondary coverage and would like our office to file there will be a $10.00 fee (this does not apply to Medicare secondary coverage). If your insurance company requests additional filing of your claims, you will be responsible for a $5 service charge for each additional filing your insurance company requests. INITIAL____**

( ) SELF PAY: Payment is due when services are rendered. **INITIAL_____**

( ) **AUTO ACCIDENT/PERSONAL INJURY:**
This office **DOES NOT** accept liability insurance as a form of payment. We do not get involved in the legal procedures; therefore payment is due at the time services are rendered. We are, however, eager to assist all patients in need of care. We will be glad to verify auto accident/personal injury benefits with your personal health insurance**. INITIAL_____**

( ) **WORKERS COMPENSATION:**
We will accept worker's compensation if your insurance carrier or employer notifies our office prior to your visit with verification and authorization for services. **WE WILL NEED A COPY OF YOUR GROUP INSURANCE CARD** to keep in your file should your worker's comp claims be denied, at which time, you would be responsible for the bill. **INITIAL____**

BENEFIT ASSIGNMENT: I hereby authorize payment be made directly to Dosher Physical Therapy Associates. If my insurance company should require that payment be made to me, I will in turn issue payment to Dosher Physical Therapy Associates for any charges that I have not previously paid and/or charges that are not covered by my insurance company.

BENEFIT ASSIGNMENT FOR MEDICARE PATIENTS: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dosher Physical Therapy Associates for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

**** There will be a $25 fee for appointments cancelled or broken without 24 hour advanced notice.** INITIAL____**

**** Any balance that remains unpaid 20 days after services are rendered is the responsibility of the patient/guardian and will be subject to a finance charge. *** Delinquent accounts will be forwarded to a collection agency if payment is not received.* ***INITIAL*****_____**

I understand that I am financially responsible for services not covered or deemed not medically necessary by my insurance company. I further understand that Dosher Physical Therapy Associates may not be aware of non covered services at the time of treatment. I have read and understand my obligation.

_____Date:_____
Patient Signature or Guardian if a minor