Drummond Physical Therapy Payment Policy

Patient Name: _____

Thank you for choosing Drummond Physical Therapy 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. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. It is also your responsibility to know whether or not pre-authorization is required, and if it is, it is your responsibility to get your treatment pre-authorized. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Self Pay, Copays, and Deductibles:** All copays 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 copays and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your copay at each visit. If you have no insurance, we do expect payment at the time of service unless you have made other arrangements with our billing department. For minor patients, the parent, relative, or other individual, escorting the patient is responsible for any payments due at the time of service and for the balance remaining after insurance has processed your claim.

3. **Non-covered Service:** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare of other insurers. You must pay for these services in full at the time of service.

4. **Proof of Insurance:** All patients must complete our patient information form before seeing a therapist. We must obtain a copy of your current insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the charges you incur.

5. **Claims Submission:** Drummond Physical Therapy will attempt to obtain payment from your insurance carrier, worker's compensation plan, or motor vehicle insurance. It is our policy to complete an initial claim form and submit it to your carrier. We will 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. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. If monthly payments are required, please speak with our billing department.

6. **Coverage Changes:** If your insurance changes, please notify us prior to your next visit so we can make the appropriate changes to help you receive your maximum benefits.

7. **Nonpayment:** I understand that I am personally responsible for paying all collection fees associated with my account, including reasonable attorney fees and reasonable collection agency fees. I understand that in the event my account is turned over to a third party collection agency, a collection fee in the amount of up to 50% of my total account balance will be added to my balance and that I am responsible for paying my total account balance plus the collection fee.

8. **Non-Sufficient Funds Checks:** Our policy is to attempt to secure funds from all checks written. If they fail on the first attempt, our bank will automatically send your check through a second time. If it is returned to us we charge our bank fees. The check would need to be covered by cash, credit card, or money order within 5 business days of our notice or it may be presented to our collection agency.

9. **Authorization and Assignment of Benefits:** By signing below I hereby assign, transfer, and set over to Drummond Physical Therapy, P.C. and/or its individual therapists, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information required to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

10. **High Deductibles:** Patients who have a deductible of $1000.00 or more are asked to pay $75.00 at each physical therapy visit. This payment will be applied toward charges for each date of service. Please note that the patient responsibility for each visit will be determined by benefits of the insurance plan and will likely exceed $75.00. A statement for the remaining account balance will be sent at the beginning of each month. Please discuss your care with your physical therapist. For available options regarding your account please contact our Billing Department for assistance.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for reviewing our payment policy. Please let us know if you have any questions or concerns.

I have read and understand this payment policy, including the Notice of Privacy Practices and the Assignment of Benefits, and I agree to abide by its terms:

_____ _____

Signature of Patient or Responsible Party **Date**

PATIENTS WITHOUT INSURANCE

Self/Direct-Pay: By signing below I state that I or the minor patient ***DO NOT*** have health insurance and will be responsible for services rendered here at Drummond Physical Therapy, P.C. I agree to pay Drummond Physical Therapy P.C. the full and entire amount of treatment given to me or to the above named patient at each visit.

_____ _____

Signature of Patient or Responsible Party **Date**