Lattimore of Physical Therapy and Sports Rehabilitation Network
Financial Policy

Payment is expected at the time services are rendered unless specific credit arrangements are made in advance.

Copay(s) are due at the time services are provided.

Patients with Medicare: Claims will be submitted to Medicare on the patient's behalf. Patients are responsible for an annual _____ deductible and 20% coinsurance. Payment for non-covered services are due at the time the service is performed. A claim will be sent to your supplemental insurance when information is provided by the patient. If a balance remains after insurance(s) have reviewed and made any payments on claims, you will then become responsible for that final payment.

Patients with Insurance: Patients are responsible for deductibles, co-payment, non-covered service, coinsurance, and items considered "not medically necessary" by the insurance company. A claim will be submitted to the insurance company when LPT is provided with the necessary billing information. Any remaining balance is due from the patient within a timely manner. If a patient or an insurance carrier pays an amount exceeding the balance, a refund will be issued to the appropriate party.

Patients with high deductible Insurance: Patients are responsible to pay out of pocket until the deductible and co-insurance amounts are met. These are usually a percentage of charges. The fee for physical therapy services are set by your insurance company. We are unable to discount fees set by your insurance company. We are requesting that the patients with high deductible plans make a $65 pre-pay at each visit. If you are not willing to make a pre-payment, we will expect payment in full within 30 days of receiving a statement from our office.

Visits per Calendar year: Your insurance has set limitations of the number of visits allowed per calendar year. If you exceed that visit number you will be responsible for charges for services. The office will discuss the options available with you.

Assignment of Benefits

I understand and agree that I am personally responsible for full payment of all physical therapy services rendered to me. I hereby transfer/assign payment of any physical therapy insurance benefits directly to

_____

Insert location name

and authorize release of any information regarding my treatment that is required by my insurance carrier to obtain such a payment.

Appointment – Cancellation and NO Show Policy

We are committed to providing you, our valued patients, excellent quality and convenient physical therapy services. **In consideration of our other patients and our staff we do require 24 hour notice for appointment cancellations**. **Not showing for an appointment creates a financial and scheduling burden, therefore we are forced to charge the fees below:**

MISSED APPOINTMENT FEES: Cancellations with less than 24 hr notice $20 per instance. No Show appointments $30 per instance.

I have reviewed and read our office(s) policies and procedures.

Signature _____ **Date:** _____