

Sandy Physical Therapy Financial Policy

Thank you for choosing us as your health care provider. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you, the patient or guarantor, to read and sign prior to any treatment. You must also complete our information and insurance form before seeing the physical therapist. PLEASE REMEMBER THAT BILLING YOUR INSURANCE COMPANY IS A SERVICE WE CHOOSE TO PROVIDE AS A COURTESY TO YOU, THOUGH WE ARE NOT REQUIRED TO DO SO.

- All co-payments are due at the time of service.
- A \$25.00 fee will be added to all returned checks.
- In order to avoid a monthly rebilling fee of \$15.00, please pay your portion, or monthly payment arranged with us no later than the 10th of each month.
- It is your responsibility to make sure all prior authorization with your insurance company is completed.

Collection Agency: Please note that in the event that you fail to make payment when due, this account may be referred to a collection agency for collection. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

Cash Accounts: Full payment is due at the time of service. We provide a 20% discount for our patients without insurance.

Non-contractual Insurance: You must have a current valid ID card for your insurance company with the billing address. We will bill your insurance company as a courtesy to you. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

Contracted Insurance: If we are currently a contracted provider with your insurance company, we will bill them for you. You must have a current insurance card with the billing address. In the event your insurance company denies the claim, Sandy Physical Therapy retains the right to bill you as the responsible party for reimbursement.

Worker's Compensation: If your claim is denied or in dispute, we will bill your regular insurance company, pursuant to ORS 656-313, for the cost of your care, excluding any applicable deductible or co-payments. While your claim is in dispute, you are required to pay any deductible or co-payments not covered by your insurance company. If you do not have medical insurance, you are personally responsible for the cost of treatment.

Motor Vehicle Accidents: If you are receiving treatment as a result of an automobile accident, you are responsible for paying any unpaid portions of your bill not covered by the Personal Injury Protection (PIP) clause of your automobile insurance. Because you are receiving these services, you have the final responsibility to pay for those services. Often a doctor will prescribe additional therapy that your insurance carrier may not deem medically necessary. Any portions of your bill rejected by your insurance carrier will be your responsibility to pay.

If your PIP is exhausted and you have provided us with your private health insurance information at your first visit, we will bill them, however, you will be responsible for any balance not paid by them including, but not limited to, co-insurance, co-payments and deductibles. If your insurance has not paid within 30 days, and you are unable to pay your account in full, you must contact our office immediately to make special payment arrangements.

If your PIP is exhausted and you do not have primary health insurance, you will be required to pay 50% at the time of service and the balance due within 30 days of your last visit, unless prior arrangements have been made. Monthly payments are still required, regardless of any legal representation or Letter of Protection on file.

Usual & Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

I agree to be responsible for my charges incurred at Sandy Physical Therapy regardless of insurance coverage.

I have read, understand and agree to this Financial Policy:

X _____ Date: _____
Patient or Guarantor