**INSURANCE POLICY**

It is our goal to provide you with the most efficient care possible and minimize any possible delays or misunderstandings that may be related to your insurance and our payment policy. Should you have any questions or need clarification, please feel free to discuss this with our administrative staff.

Advance Physical Therapy, Inc. has several contracts with insurance companies. As a contracted provider, Advance Physical Therapy, Inc. will accept the contracted rate as determined by the insurance entity but patients are solely responsible for any and all co-payments, deductibles, co-insurance (percentage of the allowed charges), and “non-covered” services that the insurance company may not authorize.

For insurance entities that Advance Physical Therapy, Inc. is not contracted with, patients will be responsible for any and all charges that the insurance company does not cover as payment.

Please note that insurance coverage is considered a method of reimbursing the patient for charges paid to the treating clinic or physical therapist and is not a substitute for payment. You are responsible for 100% of all charges incurred; your physician referral and our verification of your insurance coverage is not a guarantee of payment.

**PAYMENT POLICY**

Full payment of co-payments, deductibles, co-insurance and self-payments are due at the time of service. Payment of durable medical equipment (DME) is due at time of purchase during the physical therapy visit. Advance Physical Therapy, Inc. will assess a finance charge of 1.5% on all accounts overdue. There will be a NSF fee of $25.00 assessed for every returned or bounced check. **I understand if my account should become delinquent I will be responsible for all reasonable collection costs and attorney fees.** Initial: \_\_\_\_\_\_\_\_

**APPOINTMENT AND CANCELLATION POLICY**

If you are unable to keep your scheduled appointment, please notify our office at least 24 hours in advance prior to your scheduled appointment time so that we can offer that time to another patient. If we do not receive notice of your cancellation within this timeframe, you will be assessed a $50 cancellation fee for the office visit. **I understand if my account should become delinquent I will be responsible for all reasonable collection costs and attorney fees.**

Initial: \_\_\_\_\_\_\_\_ **CONSENT FOR CARE AND TREATMENT**

I authorize and give my consent to Advance Physical Therapy, Inc. I understand that I am financially responsible for any balance. I also authorize Advance Physical Therapy, Inc. to release any medical information required to process my claims and to receive payment.

PATIENT SIGNATURE DATE