**INSURANCE POLICY**

It is our goal to provide you with the most efficient physical therapy care and assistance through the insurance process and payment policy. Should you have any questions about your coverage and need further clarification, please feel free to discuss this with our administrative staff.

Advance Physical Therapy, Inc. is a contracted provider with Anthem Blue Cross, Blue Shield, and Medicare. As an in-network provider, Advance Physical Therapy, Inc. will accept the contracted rate as determined by the insurance entity and patients are responsible for all co-payments, deductibles and co-insurances.

For all other insurance entities, Advance Physical Therapy, Inc. is an out of network provider and will submit claims to your insurance for reimbursement. Patients are responsible for all charges, copays, co-insurance and “non-covered” services that the insurance company may not authorize for payment.

Please note that insurance coverage is considered a method of reimbursing the patient for charges paid to the treating clinic 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 and benefits is not a guarantee of insurance 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 the 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 **$75** cancellation fee for the office visit.

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

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

PATIENT SIGNATURE DATE