Progressive Therapy Alternatives, Inc.

FINANCIAL POLICY 09-20-2013

Thank you for choosing Progressive Physical Therapy. We are committed to your entire experience here being Successful, and we want you to completely understand our financial policies. You have a financial responsibility that obligates you to ensure full payment of your bill. In this agreement the words “you,” “your,” and “yours,” mean the Patient/Debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we,” “us,” and “our” refer to Progressive Therapy Alternatives Inc.

REVIEW YOUR “SCHEDULE OF BENEFITS” We urge you to review your insurance policy's “Schedule of Benefits”. It will help you understand the agreement you have with your insurance company. You should call your insurance company with any specific questions related to your policy relating to outpatient physical therapy benefits. You need to accurately verify and understand your policy's deductible, co-payment, coinsurance, visit limitations, effective annual calendar renewal date, and any pre-authorization requirements. As a courtesy, we will also verify your coverage, but we will not guarantee the accuracy of the information we receive. Your insurance policy is a contract between you and your insurance company. You are responsible to know your level of coverage, and you are ultimately responsible for the full payment of your bill.

WORKER'S COMPENSATION If you are claiming worker's compensation you must provide us with a copy of your personal insurance card. We will confirm your authorization with your case adjuster or case manager. In the event payment for your claim is denied by your worker's compensation carrier, we will file the claims with your personal insurance policy. If your claim is denied by your personal insurance, you are responsible for the full payment of your bill.

MEDICARE Physical Therapy Alternatives Inc. is a Medicare-approved provider of outpatient physical therapy. All Medicare policy holders have a maximum benefit for outpatient physical therapy services. We will monitor your visits and make you aware as you near the maximum allowed by Medicare. You are responsible to make us aware of any previous treatment you may have had at another facility in the past 12 months. Medicare will not pay for outpatient therapy services while you are receiving home services. It is your responsibility to make sure your home health agency has discharged you from their care.

PERSONAL INJURY, LIABILITY, AUTO, OR INVOLVEMENT OF AN ATTORNEY You need to complete and sign all of the patient registration forms. In the event your injury was due to an auto accident or any other accident resulting in a litigation our office will be happy to file your bills with your own auto med pay, your health insurance or the responsible parties auto insurance company if they agree to pay at the time of service, otherwise payment is due by you on the date of service. Any deductibles, coinsurances or non paid bills will be the responsibility of the patient. We do not accept attorney’s letter of protection. **We will not wait for settlement on your claim for our services to be paid**.

APPOINTMENT POLICY: When canceling, you must call at least 24-hours in advance of your scheduled appointment. We reserve 30-60 minutes on our schedule for your appointment, and we would appreciate an advanced notice so that another patient could schedule during that valuable time. If you fail to call 24-hours in advance or “no-show “ an appointment , we reserve the right to assess a $25.00 cancellation fee that is not billable to insurance. We understand that there are special and unforeseen situations that will be assessed on a case-by-case basis.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments/credits applied to your account during the month.

PAYMENT: We accept cash, check, VISA, and Mastercard. There will be a $30.00 service charge for all returned checks. If you have insurance, balances will be considered current from the date your insurance pays its portion. After that, the payment is due upon receipt of a statement from our office. We will work with you to set-up customized payment plan if necessary, please ask. The balance of your statement is due when you receive your statement.

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RETURNED CHECKS: There is a fee (currently $30) for any checks returned by the bank.

FINANCE CHARGES: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of one and a half (1.5%) percent per month or an ANNUAL PERCENTAGE RATE of eighteen (18%) percent.

PAST DUE ACCOUNTS: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs.

CONSENT FOR CARE/TREATEMENT: I authorize Physical Therapy Alternatives Inc. personnel to administer care and treatment to me in accordance with my Doctor's prescription, or other treatment considered necessary and advisable by the provider who attends me.

RELEASE OF INFORMATION: I give my permission to release medical information to my 3Rd party provider, my prospective or current employer, my insurance carrier, my employer's medical department, medical consultants, or my private physician. I authorize Physical Therapy Alternatives Inc. to obtain any diagnostic test results, including but not limited to, X-ray/Imaging Reports, that pertain to this current medical condition.

PAYMENTS DUE AT THE TIME OF SERVICE:

1. **Co-pays** that are required by your insurance policy are due at the time of service.
2. If your deductible has not been met, Physical Therapy Alternatives requires a minimum payment of $25.00 toward your policy's deductible.
3. Physical Therapy Alternatives Inc. requires a minimum payment of $25.00 per session for patients who have an in or out-of-network insurance policy and have not met their deductible.
4. If you are a Non-Insurance-Fee-for-Service patient, full payment must be received at the time of service.
5. Cancellation or no-show fees ($25.00) are due at the time of your next scheduled session

I have read and understand the above Financial Policy and agree to the conditions listed.

_____

Print Patient Name Printed Name of person authorized to consent

_____

Signature of Patient or Person authorized to consent Date

RE-OCCURRING CREDIT CARD PAYMENTS: A copy of this financial policy will also be used as a contract if a patient chooses to have our company process their credit or debit card on a re-occurring basis to cover any out of pocket costs and or their final bill. Any of the arrangements above will be noted at the bottom of this document and the signature will define its agreement.

Credit Card Information

Card Type VISA - Mastercard - Discover

Card:_____Exp:_____CV#:_____

Billing Zip Code: _____ Copay Amount $_____

Other Amount $_____