PARAMOUNT
PHYSICAL THERAPY

Financial Policy Statement

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third-party payers to Paramount Physical Therapy.
Initial: _____

Patients with Insurance: If you have health insurance, Paramount Physical Therapy will submit claims to your primary and secondary insurance carriers on your behalf and allow no less than 60 days for the insurance company to respond. However, you are required, and you agree, to pay at time of service any required co-payments and deductibles, as well as any outstanding balances, delinquent accounts, and any charges for services not covered by insurance. For your convenience, we accept cash, checks and credit/debit cards. By signing this document, you acknowledge that your insurance company may determine that the services provided are not covered under your insurance policy and agree that, if your insurance company determines that any services are not covered, you shall be responsible for, and shall pay, the cost of any such services. It is your responsibility to notify Paramount Physical Therapy of any changes in your insurance coverage.

We do our best to verify your plan benefits with your insurance company as a courtesy to you. However, benefits that we are quoted by your insurance company are not a guarantee of payment. Actual benefits are determined by your insurance company at the time the claim is processed. Co-pays and co-insurance (percentage) will be collected at the time services are rendered. Co-insurance amount will be determined by an estimate of the percentage of the cost of a typical visit. If the percentage amount is inaccurate, the correction will be adjusted through reimbursement or a final bill. When payment from your insurance company is received, we will know then if we have to modify your out-of-pocket contribution. If a deductible is not yet reached at the time of service, your insurance provider will inform you, and you will become responsible for those charges. If your insurance has not processed claims for services provided to you within 60 days, we reserve the right to bill you directly for the balance in full, at which time you will be responsible for following up with your insurance carrier.
Initial: _____

Self-Pay: If you do not have health insurance or elect “Self-pay”, you are required, and you agree, to pay at time of service, all charges as well as any outstanding balances and delinquent accounts. The “Self-pay” rate is a flat fee of $120/visit. If you pay by check, and your check is dishonored or returned for any reason, we will expect payment in full plus a returned check fee of $50 within 30 days of the returned check.
Initial:_____

Patients with Worker’s Compensation: If you claim Worker’s Compensation benefits, we will promptly send all claims to the claim adjustor as provided. Please be advised if you claim Worker’s Compensation benefits and are subsequently denied such benefits, you may be held responsible for, and expected to pay, the total amount of charges for services rendered to you.
Initial:_____

Under the assignment of benefits agreement above, if any payment is made directly to you, or to an attorney acting on your behalf, for services billed by us, you recognize your obligation to promptly remit the same amount to Paramount Physical Therapy.
Initial:_____

I acknowledge that balances older than 90 days may be assessed an 18% annual percentage rate (APR) finance charge (1.50% per month). If any debt is owed to the Clinic and is referred to an attorney or collection agency for collections, I agree to pay all attorney and collection fees in the amount of thirty-three percent (33%) of the total indebtedness, including all court costs and filing fees incurred by the Clinic. I understand and agree that should Paramount Physical Therapy be awarded judgment relating to this agreement or any debt incurred thereof, I will pay a service charge of one and one-half percent (1 1/2%) per month or eighteen percent (18%) per annum, beginning on the date of judgment.
Initial: _____

I HAVE READ AND FULLY UNDERSTAND THE ABOVE FINANCIAL POLICY STATEMENT AND AGREE TO ITS TERMS.

Guarantor: _____ Relationship: _____
Print Please

Signature: _____ Date: _____