

PATIENT AGREEMENT

Due to limited space and potentially dangerous equipment, patients are discouraged from bringing small children to our facility. Joint Effort Physical Therapy LLC is not responsible for any injuries suffered by unsupervised children.

We attempt to obtain benefits from your insurance company and give you the best information possible. However, **Joint Effort Physical Therapy will not be responsible for any discrepancies between quoted benefits and actual benefits paid by your insurance.** We do encourage you to call your insurance company and verify speech, occupational or physical therapy benefits. It is your responsibility to know and understand your plan limitations, maximum benefits available, deductibles, copayments and coinsurance amounts. **You will be responsible for payment of amounts not covered by your insurance.**

For patients with private health insurance, **estimated** co-insurance payments will be collected at each visit. Example: patients owing 20% co-insurance should expect to pay \$10-\$19 at each visit. If your co-insurance is 10%, we will collect \$5-\$11 per visit. Again, these amounts are estimates of your co-insurance liability and do not represent payment in full. Final calculation of your co-insurance liability will be done after all payments have been received from your insurance carrier. At that time, you will receive a statement for any remaining balance due, or you will be promptly refunded for any overpayment, whichever may apply.

Deductibles owed are handled in the same manner. We collect \$50-\$75 at each visit as an **estimated** amount that will be applied toward your deductible until your deductible has been met. This does not represent payment in full for your daily treatment. Once the deductible has been met, if applicable, we will then collect towards your co-insurance in the same manner as stated above.

For patients with a fixed co-payment amount for each visit, please be prepared to pay your co-payment at each therapy appointment.

A \$20.00 fee will be charged on all returned checks. Statements not paid by due date shown will be assessed a \$5.00 rebill fee.

AGREEMENT: I understand and agree that I am responsible for verifying my own insurance benefits. Because my insurance coverage is a contract between myself and my insurance company, I understand that I must direct questions or concerns regarding payment of benefits to my insurance company. I agree to pay all charges for me and my family members shown by statement within 30 days after receipt, unless credit arrangements have been made. Charges are to be paid in full regardless of any arbitrary decision made by my insurance company regarding usual and customary fees. It is agreed that payment will not be delayed or withheld because of any insurance claims pending, and all proceeds of insurance are assigned to this office where applicable (a copy of this assignment is as valid as the original). In the event legal action should become necessary to collect unpaid balances due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the court determines proper.

Patient or Responsible Party : _____ Date : _____

CANCELLATION / NO SHOW POLICY

Your scheduled appointment is a specific time when your therapist will work with you. It is imperative that you attend each appointment and be on time. Our goal is to help you get better and the only way that can be accomplished is for you to attend therapy. If you are unable to keep your appointment, we ask that you call to cancel at least **24 hours** in advance or we reserve the right to charge you a **\$25 fee**. Failure to attend your scheduled sessions may hinder your recovery as well as disrupt the therapist's schedule.

In addition, if you fail to keep **three** appointments, you will be dismissed from therapy and will be required to return to your physician to obtain a new prescription before you may resume rehabilitation.

Patient or Responsible Party: _____ Date: _____

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