Rebound REHABILITATION PHYSICAL THERAPY

OUR FINANCIAL POLICY

Welcome to our office. We are committed to providing you with the best possible care. We are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy or your responsibility. In order for you to fully benefit from your insurance coverage we have adopted the following policies;

As a courtesy, Rebound Rehabilitative Services will bill charges to your insurance company for you. Please provide a copy of *all* insurance information in order to maximize the amount of your charges paid by insurance. Our ability to file your insurance claim efficiently is dependent on you providing accurate insurance information. Do you have more than one insurance? _____

Insurance is a contract between you and your insurance company. We are not a party to this contract. We will handle your claims according to our contractual agreement with the insurance company, if one exists. We cannot become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered or non-covered charges, "usual & customary charges", etc., other than to supply factual information.

You will need to check on all authorizations necessary for your care. A prescription is valid for 30 days from the date written. Updated prescriptions are occasionally needed and it is the patient's responsibility to obtain a new prescription. Our office will inform you of the need for a new prescription.

Payments of deductibles, co-insurance's and co-payments are required prior to treatment. We cannot waive your co-payment. We accept cash, check, Visa and MasterCard. There will be a $25 fee for any returned check. You are ultimately responsible for timely resolution of any outstanding balance on your statement. Copayments are a contractual agreement between the insurance company and the patient. Any claims not paid, by your insurance company, within 45 days of the date of service, will become your responsibility for follow up or payment.

Some insurance policies combine benefits for **Physical Therapy, Occupational Therapy, Podiatric and Chiropractic services.** Before seeing any combination of these providers, on the same day, check on your insurance benefits.

If you have secondary insurance we will file the claim for you **ONE TIME.** If refiling is necessary it will be your responsibility, unless it is due to an error on our part. If payment from your secondary carrier is not received within 60 days of your date of service, you will be responsible for the balance and follow-up. You will be sent a statement indicating the balance due. Please call if you wish to have a more detailed statement sent to you.

FINANCIAL RESPONSIBILITY PARTY

Legal Name: _____ Relationship: _____ Date of Birth: _____

Address: _____

Home Phone # _____Work Phone # _____ Ext: _____ SS# _____

Thank you for understanding our Financial Policy. We are here to help you. Please let us know if you have questions or concerns. I acknowledge receipt of a copy of this policy. CC to pt on _____ by _____

Responsible Party Signature _____ Date: _____