Progressive Physical Therapy

Financial Agreement

Patient Name: _____ Account #: _____

As a courtesy to you, Progressive Physical Therapy will file claims to your medical insurance company for the services that are provided by our office. In order for the claims to process correctly, please ensure that the information provided to our office is accurate and current. If there is a change in your insurance information, please notify us immediately.

Co-payments are **constant** and due at the time your services are rendered. Coinsurance and deductibles vary for each insurance policy and we can only approximate the percentage covered by each plan.

Medical insurance coverage is a contract between you and your insurance company. We ARE NOT a party to this contract. We will not be involved in disputes between you and your insurance company regarding verification of benefits, deductibles, co-payment, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. **You are ultimately responsible for verifying all benefits, the timely payment of your account, and any outstanding or uncovered services.**

PAYMENT METHODS AND OTHER INFORMATION:

- We accept cash, check and VISA or Mastercard
- Accounts that are past due will be turned over to a collection agency and a collection fee will be assessed
- Home supplies are not covered by insurance and must be collected for at the time they are received

WORKERS' COMPENSATION POLICY

- If you are a workers' compensation patient, it is our policy to bill your employer or the workers' compensation carrier for services rendered.
- If you are covered under workers' compensation, we will accept the payments by the workers' compensation carrier as per contracted rates based on the mandated SC state fee schedule.
- It will be your responsibility to contact us with the name and address of your employer or the insurance company that covers your employer.

Progressive Physical Therapy is committed to providing you with the best possible care and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please do not hesitate to ask if you have any questions about our fees, financial policy or your financial responsibility.

****I acknowledge that I have read and agree to the above Financial Policy.****

Patient or Authorized Persons:

X

_____ _____

Signature Date

Progressive Physical Therapy Representative:

X

_____ _____

Signature Date