ADVANCED CENTER FOR PHYSICAL THERAPY, PLC
FINANCIAL POLICY

TO OUR VALUED PATIENTS:

We are committed to providing you with the best possible care. If you have medical insurance, we want to ensure that you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Co payments and unmet deductibles are due at the time of service. Payment for services when applicable is due on each visit for charges incurred up through your last visit. We accept cash, checks, MasterCard, Visa, or Discover. A fee of $25 will be charged for every returned check. We bill electronically, to expedite payment of claims.

Please read carefully:

1. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. "U.C.R." is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility.
4. If this injury is work related, and a Workers Compensation claim has been initiated, you are given 10 visits with no claim number, if after the 10th visit, a claim number has not been received, or your case is denied by WC insurance company or VDOLI, then you are responsible for all of the appointments. We require, on your initial visit, that you provide us with your medical insurance to insure payment of the account if your case is not allowed. If you already have a claim number, please provide us with the number and the date of injury on the registration form.
5. For liability cases, where another party may be responsible, you must provide us with all the billing information. If you have an attorney, please provide this information on the registration form. It is this office's policy that a letter of protection must be received from your attorney within the first 2 weeks of your treatment. Without this letter, you become responsible for the account in full.
6. Your adherence to the recommended number of treatments is a vital component of your progress with our services. Our office requires a **12-hour notice for cancellation of appointments** and reserves the right to charge you **$25 without 12 hour notice**; you can call and leave a message on the answering machine if needed. We realize conflicts with work, other activities, or unexpected illness may require you to call and reschedule, however, there will be a $25.00 charge for a missed appointment without notification to the office. If there is repeated non-compliance with your scheduled appointments, ACPT reserves the right to discontinue care and inform your physician of the fact due to non-compliance with the prescribed rehabilitation order.
7. 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 an attorney, you agree to pay all attorney's fees which we incur plus all court costs. We have the option to report your account to any credit reporting agency such as a credit bureau.

Again, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We may contact appropriate family members for medical claims processing purposes. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Authorization for Treatment & Assignment of Medical Benefits

I have read the above policies and agree. I authorize Advanced Center for Physical Therapy, PLC (the Provider) to render to patient physical therapy or other related services (collectively "therapy services") that Provider or patient's treating physician determines may be necessary or advisable. I assign to Provider all Medicare and/or private insurance benefits (primary and secondary) or other benefits to which patient may be entitled for any therapy services rendered on behalf of patient. The information that patient has provided is true and accurate in all respects.

Patient's Name: ____

SIGNATURE: ________________________________ **DATE:** ________________

Patient/Legal Representative/Financially responsible Party (if under age of 18)

ACPT witness: ________________________________ **DATE:** ________________

Copy given to patient: YES ____ NO____

Updated 6/29/09nt