FINACIAL AND INSURANCE POLICY

Thank you for choosing AXCESS PHYSICAL THERAPY as your health care provider. Please understand that payment is considered a part of your treatment. Your clear understanding of our financial policy is important to our professional relationship.

- All patients must complete our Patient Registration Information, Health History, Credit Card and HIPAA forms prior to your appointment
- CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE
- We accept cash, checks, Visa, MasterCard, Discover and we work with CareCredit

INSURANCE PLANS

If you have a managed care plan (PPO, EPO, POS or HMO), co-payments are due at the time of service in addition to any deductibles or fees for which you are responsible. Insurance is a contract between you and your insurance company. We are not a party to this contract. By law insurance companies are required to pay healthcare providers within 30 to 45 working days. You are responsible for the timely payment of your account. Some health plans do not cover all services. **If we are aware that your plan excludes certain services, you will need to pay for those services in full when services are rendered.**

If this account is assigned to our collection agency, Creditors Collection Bureau, Inc., the undersigned agrees to pay all collection costs incurred, in an amount not to exceed fifty percent (50%) of the unpaid balance, in addition, should any unpaid balance due be referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid for by the undersigned as allowed by court. **All balances are due within 30 days of statement date. A late fee of $25.00 will be assessed for any balance over 30 days past due, and $50.00 over 60 days past due** unless alternative payment arrangements have been made prior to treatment.

MEDICAID/PUBLIC AID

If you are covered by Medicaid/Public Aid, you must present medical eligibility proof at each appointment or you will be responsible for the entire fee.

RELEASE OF INFORMATION AND AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I authorize **Axcess Physical Therapy** to release to my insurance company or its representatives, information including the diagnosis and records of any treatment or examination rendered to me that they might require to process my claim for benefits. I authorize and request that my insurance company pay directly to the above named practice the amount due to me. This assignment will remain in effect until revoked by me in writing. I understand and agree that (regardless of my insurance policy); I am responsible for the entire balance on my account, for all professional services provided to the patient or myself. I have read all the information contained in this Financial Policy. I certify that , to the best of my knowledge, this information completed on the Patient Information Form is correct. I will notify this office in case of any changes to my health or any of the attached information.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices, and that I have read and understood the Notice.

ALL PATIENTS:

Date:_____ Patient's Name Printed:_____

Signature:_____
Patient, Parent or Authorized Representative's Signature

MEDICARE PATIENTS ONLY: Initial here and sign above:_____