Middleburg
SPORTS & ORTHOPEDIC
PHYSICAL THERAPY

FINANCIAL POLICY AND CONTRACT

Dear Patient,

We will bill your insurance for the physical therapy services. Our office staff is experienced and will help you get maximum benefit from your policy. You must read your policy and be familiar with its main features. Ask our Office Manager for help to understand its benefits. We will verify your insurance coverage by your second appointment and notify you if we need more information. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.

Please read and sign the following Policy and Contract. Ask the Receptionist or Office Manager if you have any questions.

1. Your policy may pay less than our customary fee. Not all services are a covered benefit in all policies. You should discuss payment of the balance with the Office Manager.

2. The insurance company is your company. Your insurance policy is a contract between you, your employer and the insurance company. Do not hesitate to call them if you have a question regarding payment. This document is a contract between you and Middleburg Physical Therapy.

3. We should receive payment from the insurance company within 45 days. After 45 days, you are responsible for the balance.

4. You must make arrangements to pay the percentage not covered by your policy, if your policy pays less than 100%. You will receive a statement (at least monthly) indicating the balance due. Payment is due at the time services are rendered. We accept cash, checks, Mastercard or Visa.

5. If you have a co-pay, you should pay when you arrive for each appointment.

6. By signing this document, you are promising to pay any balance left after insurance proceeds are received by Middleburg Physical Therapy.

Cancellations Please notify us as soon as possible if you must reschedule your appointment. 24-hour notice is required. If a cancellation is made less than 24 hours in advance and the time cannot otherwise be filled, a **$75.00** charge will apply.

No Shows Missed appointments without notification are charged **$75.00** due to the scheduling inconvenience. This is NOT paid by insurance.

Litigation & Third-Party Payor We do not see patients with the expectation of payment contingent on the outcome of any litigation. If you are anticipating payment for services by another party's insurer, we still expect payment when the service is rendered. We will bill your insurance on your behalf. You should pay any percentage not covered by your own policy.

Interest Charge

Services paid for within ninety (90) days of the service date are not subject to an interest charge. An **18% per month** interest will be charged to all balances over ninety (90) days old.

Changes To This Policy

We reserve the right to change this policy. We reserve the right to make the revised or changed policy effective for charges we have already billed. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

Attorney's Fees

You agree to pay, in addition to the balance due and the applicable finance charge, an amount equal to **thirty-three and one-third percent (33-1/3%)** [or the maximum permitted by law, whichever is less] of the balance due as attorney's fees if this account is referred to an attorney for collection.

I understand and agree (regardless of my insurance status) that I am ultimately responsible for the balance of my account for any professional services rendered.

I certify that all information is true and correct to the best of my knowledge. I will notify you of any changes in my health insurance status of the above information.

I certify that I have read both sides of this document and agree to the terms and conditions herein.

PRINT FULL NAME _____

PLEASE SIGN **X** _____ _____
Signature Date

PARENT(S), IF PATIENT IS A MINOR _____

MPT, FOR OWNER _____

ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be paid directly to the Physical Therapy practice and agree that I am financially responsible for all non-covered services including interest, cancellation, and no-show charges. I also authorize the physical therapist to release any information required to process insurance claims.

Please feel free to discuss any facet of your medical insurance coverage with us.

AGREED:

PLEASE SIGN **X** _____ _____
Signature Date

_____ _____
Signature of Insured, if not the Patient Date