Optimal Physical Therapy LLC
Orthopedic • Work • Sports

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Payment Policy

Thank you for choosing us as your physical therapy provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. A copy will be provided to you upon request.

a. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. *Knowing your insurance benefits is your responsibility*. Please contact your insurance company with any questions you may have regarding your coverage.

b. **Co-payments, coinsurance and deductibles.** All co-payments, coinsurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments, coinsurance and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment or coinsurance and deductibles at each visit. We would also be happy to set up a monthly payment plan should you need to.

c. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

d. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

e. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. It is your responsibility to advise us if your insurance changes prior to your next visit.

f. ***Nonpayment.*** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to collections.

- **Forms of Payment Accepted: (Cash, Check, Visa, MasterCard, Discover)**
- **Returned checks will be subject to a Non Sufficient Fund fee of $25**

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See page 2 for signature

Appointment No Show and Cancellation Policy

In order to provide the highest quality care to our patients, we have established a formal "No Show/Cancellation Policy". This is intended to increase the clinic's productivity. Failure to keep your appointments hinders our ability to provide the best care for you and other patients. We will make every effort to accommodate your scheduling needs. In return we ask that you help us by keeping your scheduled appointments, and if you are unable to do so, by notifying us in advance.

Please read and sign our policy as indicated below.

- You are allowed **one free missed appointment**, after that, patients, who fail to arrive for their scheduled appointments or who cancel with less than 24 hours' advance notice, will be charged a missed appointment fee.
- **PLEASE CALL TO CANCEL APPT, WE CAN'T GUARANTEE WE WILL RECEIVE AN EMAIL ON TIME**
- The missed appointment fee of **$50.00** is to be paid at the time of your next visit.
- The missed appointment fee is **not** covered by insurance plans and is the patient's responsibility to pay.
- Repeated no shows and cancellations may result in you being discharged from physical therapy. In the event that you are discharged, your referring provider or case manager will be notified of the reason for your discharge.
- We will give reasonable consideration of circumstances for late cancellations due to unforeseen emergencies or illness.

I understand and agree that I am responsible for giving 24-hour notice if cancelling an appointment. I further understand that I will be charged for repeated no shows and cancelling without 24 hours' notice.

Thank you for understanding our payment and cancellation policy. Please let us know if you have any questions or concerns.

Patient Name: _____ Date: _____

Patient/Parent/Guardian Signature: _____

CREDIT CARD ON FILE POLICY

At Optimal Physical Therapy, we require keeping a credit or debit card on file as a means of convenient payment for patients and to protect our time as a medical provider. We can assure you that your information will be held securely until your insurances have paid their portion and notified us of the amount of your share. Your credit card will only be charged if you have an outstanding balance and is past 60 days due OR have an outstanding No Show/ Late Cancel fee. Insurance balances will be charged every *first* Tuesday of the month and No Show/ Late Cancel fees will be charged on the date of service missed. Any patient with a balance of $100.00 or more will be contacted by phone to confirm the charge. Instead of receiving an invoice in the mail monthly, you will receive a copy of the charge and receipt.

Patients with a verified Worker's Compensation or Automobile Insurance claim are exempt from having a credit card on file.

If you have any questions about this new policy, do not hesitate to ask.

I authorize Optimal Physical Therapy, LLC to charge the portion of my bill that is my financial responsibility ONLY after it is 60 days past due OR I have been charged a $50 No Show/ Late Cancel fee to the following credit/debit card:

☐ **American Express** ☐ **Visa** ☐ **Mastercard** ☐ **Discover**

Credit Card Number _____

Expiration Date _____ / _____ / _____

Cardholder Name _____

Signature _____

Billing Address _____

City _____ **State** _____ **Zip** _____

*****This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give 60 day notice to Optimal Physical Therapy, LLC by phone call.