PATIENT FINANCIAL POLICY

The Summit Therapy Center of Wooster, LLC 4419 Cleveland Rd. Wooster, Ohio 44691

Patient's Name_____ Date of Birth_____

Responsible party (if other than patient, patient is under 18 years of age)_____

Patient (or responsible party) agrees to pay for all portions of services determined by your insurance company (co-payments, deductibles, and non-covered charges). Co-payments or any uninsured charges are due in full at the time services are provided by our office.

Commercial Insurance Carriers: **You are required to present a valid insurance card upon your initial evaluation and as needed throughout your care.** We will bill most insurance carriers for you if proper paperwork is provided to us. Once verification of benefits is obtained, any outstanding balances, **co-payments, and deductibles are due at the time of your appointment.** Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you. We do not participate in cases for Worker's Compensation.

Professional Fees: **For those billing their insurance, the initial evaluation will be billed at $140.00 with subsequent visits billed at $130.00. For people without insurance and choosing to Self-Pay, the fee is $100 per hour.** Other professional services (i.e., legal reports, court appearances, treatment summaries, professional consultations, and telephone conversations) are also billed at the same hourly fee but are not billable services to insurance companies. All prior balances must be paid in full before requesting any of these additional services.

No-Show Policy: You will be charged $50.00 for any missed appointments that are not cancelled 12 hours prior to your appointment. Insurance does not provide coverage for missed appointments.

Methods of payment: **Cash, personal checks, credit and debit cards are accepted except American Express cards.** All **co-payments and deductibles are due at the time of your appointment.** You may also receive a statement of your account indicating a balance due, after insurance has processed claims. **This requested payment is due upon receipt.** In circumstances of unusual financial hardship, we are willing to set up a payment plan in which you will be required to sign the Patient Promissory Financial Agreement.

Bad Debts: Returned checks are assessed a $30 NSF charge and will be report to the local district attorney's office if not paid within 10 days of being returned to our office. Finance charges will be assessed on any account in violation of the designated payment agreement. If accounts past 120 days are not paid according to the terms, the patient understands that The Summit Therapy Center will use legal means to secure payment by filing with an outside collection agency or small claims court. In the event that your account is turned over for collections, you or the patient agrees to pay all fees assessed in the collection of that debt. We reserve the right to disclose all billing and account balance data necessary for collection of past due services.

I have read, understand and agree to the above Patient Financial Policy for payments of professional fees

Signature_____ Date_____

Rev.: 4/1/19