Patient Financial Policy

The SUMMIT Therapy Center
4419 Cleveland Rd, Wooster, OH 44691
Ph: (330)345-8450 Fax: (330)345-5899

Patient's Name: _____ Date of Birth: _____

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

Patient (responsible party) agrees to pay for all portions of services determined by your insurance company (copayments, deductibles, and non-covered charges). Co-payments or any uninsured charges are due in lull at are 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 with Medicaid or file cases for Worker's Compensation at this time.

Professional Fees: Our hourly rate is $100 with the initial evaluation billed at $110.00. Other professional services (for example: legal reports, court appearances, treatment summaries, professional consultations and telephone conversations) are also billed at the same hourly fee and are not billable services to insurances. All prior balances must be paid in full before requesting any of these additional services.

Methods of payment: Cash, personal checks, credit or debit cards are accepted . 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 because it now takes most insurance companies over 8 weeks to process and pay. Please promptly pay your bill so we may continue to stay in business to help you. In circumstances of unusual financial hardship, we will try 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 reported 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 past-due accounts 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 a third party collection agency or with small claims court. In the event that your account is turned over for collections, you/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 the collectlon of past due services.

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

_____ _____
Signature Date