SOUTHERN REHAB PHYSICAL THERAPY POLICIES

FINANCIAL POLICY

PATIENTS WITH INSURANCE:

As a courtesy to you, our staff will verify your benefits and eligibility with your insurance company prior to your first appointment. Insurance verification will determine co-payment, estimated coinsurance and or any deductible amounts at the time of service. If payment cannot be made at the time of service, a payment arrangement can be requested. Please check the box below if you need to request a payment arrangement.

Final determination of benefits is made once payment has been received from your insurance company. Any remaining balance is due in full 30 days after your first statement. If the balance is not paid in full after 3 consecutive statements and a payment arrangement has not been made, the account will be placed in a collection status. Additional fees and interest are applied to all accounts in a collection's status.

NON-INSURANCE PATIENTS: All patients without insurance will be required to pay in full at the time of service. If payment cannot be made in full, please check the box below to request a payment arrangement.

CANCELLATION/NO-SHOW POLICY **(INCLUDED IN NEW PATIENT PAPERWORK)**

- We understand situations arise beyond your control; therefore, we allow two (2) less than **24 hours' cancellations** without proper notice. However, after two (2) **less than 24 hours' cancellations** you will be charged the *Appointment Cancellation fee* of **$20.00**.
- If you *No-Show* for an appointment you are subject to the *No-Show fee* of **$20.00**.

_____ (patient initials) I understand the fees listed above are charged to me, the patient, not the insurance company, and are **due at the time of my next scheduled appointment.**

THE UNDERSIGNED AGREES SIGNING AS THE PATIENT OR AS A GUARANTOR, TO GUARANTEE PAYMENT OF THE ACCOUNT IN ACCORDANCE WITH THE STANDARD RATES AND TERMS OF SOUTHERN REHAB PHYSICAL THERAPY. I UNDERSTAND THAT ANY BALANCE REMAINING AFTER INSURANCES APPROVES OR DENIES PAYMENT IS MY RESPONSIBILITY TO PAY.

I will be paying $_____by: ☐Cash ☐ Check ☐ Visa/Discover/Mastercard

☐ Per visit ☐ PAYMENT ARRANGEMENT **$25.00 Service Charge on All Returned Checks**

PATIENT SIGNATURE: _____ DATE: _____

(INFORMATION BELOW IS TO BE COMPLETED BY SRAPT STAFF)

Today's Date: _____Verification method: _____

Primary Policy: _____ Effective Date: _____

Ded: _____ Ded Met ☐ Yes ☐ No Co-insurance %: _____Co-Pay: _____

Prior Auth Req'd ☐Yes ☐No

Limitations: _____Remaining benefits/visits: _____ Includes Chiropractic ☐ Yes ☐ No

Notes: _____

Secondary Policy: _____ Effective Date: _____

Ded: _____ Ded Met ☐ Yes ☐ No Co-insurance %: _____Co-Pay: _____

Prior Auth Req'd ☐ Yes ☐ No

Limitations: _____Remaining benefits/visits: _____ Includes Chiropractic ☐Yes ☐No

Notes: _____