

## **Choice One Physical Therapy Financial Policy**

### **Welcome To Our Office**

We are dedicated to providing you with the best possible care and service, and we regard your understanding of our financial policies as an essential element of your care and treatment. If you have questions about your account, charges, insurance, or payments, please speak with one of our Billing Representatives.

Please have available at the time of your visit the following insurance and identification information:

1. Your insurance identification card so that we may copy the front and back of the card for accurate insurance information.
2. Your drivers license so that we may copy the card for accurate demographic and patient specific data.
3. If you have a health plan that requires its own insurance claim form, please provide us with a signed and completed claim form.
4. Your referral or authorization for services when applicable.

### Payment Policy

Payment in full is expected at the time service is rendered. For your convenience, we accept cash, check, or credit cards. We will bill those insurance companies with which we have an agreement. Please note that in the event of non-payment, the account may be placed with an outside collection agency and the expenses will be added to your account balance. Balances that exceed 90 days from the date of service may be charged a finance fee of 1.5% per month. If you have any questions, please feel free to ask one of our representatives or our Billing Service.

### Self-pay Accounts

If you do not have a valid insurance plan to cover the cost of our services, you will be required to make full payment at the time of service.

### Insurance Plans

If you are insured, we will bill those insurance plans with which we have an agreement. However, it is ultimately your responsibility to become familiar with the details of your insurance plan coverage. We recommend you contact your insurance company prior to any service so you may understand your allowable benefits. If you have a PPO or HMO insurance plan, we will collect the required co-payment, co-insurance, and any deductible that is due at the time of the visit. In the event that your health plan determines a service to be “non-covered,” we will bill you, and payment is due upon receipt of that statement. Any amount not paid by your insurance company within 30 days will be billed to you. If your insurance coverage is with a plan that we do not have an agreement, payment is expected, in full, at the time of service. As a courtesy, we will submit a claim to your insurance company on your behalf.

Medicare

Your physician may or may not be a participating Medicare provider. If your physician is a participating provider, we will bill your Medicare insurance and your supplemental, if you have one.

Third Party Liability Injuries

For patients who have been involved in a liability/third party accident, payment in full is expected at the time of service.

Workers' Compensation

If you are involved in an "on-the-job" work injury, prior to seeing the physician, the following information must be obtained and verified prior to your visit:

- Date of Injury
- Case or claim number
- WCAB#, if applicable
- Workers' Compensation carrier information
- Adjuster's name
- Adjuster's telephone number
- Employer

Insurance Updates

Due to frequent changes in insurance plans and the benefits offered under those plans, our staff is required to review and update your insurance information on a regular basis.

Other Fees

- Copy of Records
- Copy of X-rays
- Form Completion Fees

**I understand that COPT agrees to bill my insurance as a courtesy and that I must submit information as needed to ensure payment for services. I further understand that I am ultimately responsible for payment for all services.**

\_\_\_\_\_  
Name of Patient (please print)

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Interpreter/Representative Name

\_\_\_\_\_  
Interpreter/Representative Signature

\_\_\_\_\_  
Date