DYNAMIC PHYSICAL THERAPY SERVICES P C
ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

TO OUR VALUED PATIENTS:
We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

We accept cash, checks, Credit Cards. We bill electronically, to expedite payment of claims. If you have an insurance that requires a paper claim to be completed, we will gladly mail this claim for you.

Please read carefully:

1. **PAYMENTS**- Copayments and payment for services are due at the beginning of **EACH** visit. If you have a deductible or coinsurance, we will estimate your responsibility to be paid on each visit and you will be billed or credited any balance as applicable once all claims have processed.

2. **IN NETWORK/OUT OF NETWORK**-Your insurance is a contract between you, your employer and your insurance co. We are a participating provider for most insurance companies. If we are in network, we will charge you no more than our contractual rate with your insurance company if applicable. If we are out of network with your insurance company and your claims are submitted to your insurance company, you will be responsible for all reasonable and customary charges as indicated on the explanation of benefits received from your insurance company. For more clarification on this, please speak with our front desk.

3. **BENEFIT LIMITS**- Some insurance plans have a financial or visit limit for physical therapy services. It is ultimately your responsibility to know your benefit limits. We have procedures in place to help you stay beneath any limits, but again it is ultimately your responsibility to keep track of your limits as if you exceed your limit, you will be responsible for charges not paid by your insurance company due to the exhaustion of your benefits.

4. **EXPIRATION OF CURRENT POLICY / CHANGE IN INSURANCE POLICY –** It is your responsibility to inform our office in a timely fashion of any discontinuation /change / expiration of coverage. If there is a non payment or a demand of return of payment by your insurance company, you will be responsible for the charges for Physical Therapy services rendered to you.

5. **WORKERS COMPENSATION**-If your injury is work related, and a Workers Compensation claim has been initiated, you must provide our office with your claim number, adjuster's name and phone number before your initial visit. Please be advised that if your account is not paid by your comp. carrier, you will be responsible for all charges within 30 days of notification.

6. **LIABILITY CASES**-For liability cases, where another party is responsible, you need to provide us with all the billing information. If you have an attorney, please provide this information on the registration form. You need to sign a Lien if there is a third party involved. Please speak to the front desk staff if you have any questions.

7. **MISSED APPOINTMENT POLICY**-Our office requires a 24-hour notice for cancellation of appointments; you can call and leave a message on the answering machine if needed. We realize conflicts with work, other activities, or unexpected illness may require you to call and re schedule, however, there will be a $25.00 charge for a missed appointment without timely notification to the office.

Our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

I have read the above policies and agree. I have accepted Dynamic Physical Therapy Services P C to provide Physical Therapy treatment. I authorize and request payment of benefits directly to Dynamic Physical Therapy Service P C. and I authorize the release of any necessary medical information to process this claim.

SIGNATURE:_____ **DATE:** _____