

WEST END

R e h a b

Physical Therapy

OFFICE POLICIES

INSURANCE

You may or may not carry insurance under which a percentage of our fees are covered. You should know that all professional services furnished by us are charged directly to the patient, and that he or she (or the financially responsible party) is personally responsible for payment. While we cannot render service on the assumption that our fees will be paid by an insurance company, we will file your insurance claim form and confirm coverage for our services by your insurance company. In special circumstances, we may be unable to bill your health insurance company/companies directly. Patients are responsible for services not covered by insurance. Overall, patients are ultimately responsible for knowing the details of their coverage (e.g., percent of coverage, deductibles, co-payments, limits on number of visits or dates of coverage, your referring physicians' or our status as a preferred provider, etc.), which may determine the extent of your financial responsibility.

SCHEDULING

Please schedule well in advance, especially if you need special hours.

CHILDREN

In order for you and other parents to receive maximum benefit from therapy, it is preferable not to be distracted by bringing children. The clinic cannot take responsibility for children accompanying their parents to therapy. Please make child care arrangements prior to appointments.

Again, we welcome you to our office and we are eager to answer any questions you may have regarding treatment.

FINANCIAL AGREEMENT

We would like to take a moment to welcome you to our office and to assure you that you will be receiving the very best care available for your condition. To familiarize you with the financial policies of our office, I would like to explain how your medical bills will be handled.

Payment Arrangements

Charges for treatment are due at the time the service is provided unless we are part of your insurance plan. We ask that you make payments on a visitational basis. Your balance must be paid in full on or before the 1st day of the following month, and any unpaid balance will be considered past due on the 5th of the month. An interest charge of 1% per month may be applied to all past due balances. If other arrangements are needed, we will be happy to discuss payment options with you. Once your insurance has been billed, we require balance not covered by insurance to be paid within 30 days. Co-payments and non-covered services are to be paid at time of each visit. Late cancellation charges are to be paid prior to your next visit. This is a \$45 charge.

Voluntary Termination of Care:

It is also the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable.

We hope that this has answered any questions you might have regarding your financial arrangements. Once again, we'd like to welcome you to our office. If, at any time, you have any questions about your care, please don't hesitate to ask.

I have read the above and agree to the above West End Rehab Physical Therapy office policies and financial agreement.

Patient/Guardian Signature

Date

In the event of emergency, need for rescheduling or unforeseen issues, list contact person(s) not living with patient:

NAME	ADDRESS	TELEPHONE