PAYMENT AGREEMENT

Today's Date____/____/_____

Patient Name:_____

INSURANCE INFORMATION

As a courtesy to our patients, we will verify and file your insurance company; however, we can not guarantee payment. We strongly suggest you contact and read your insurance policy for physical therapy benefits. Many insurance companies have stipulations; such as usual (customary) fees, limited therapy sessions, limited reimbursement per session, deductibles, co-pays, co-insurance, etc. Our agreement is with you, and not your insurance company, for receipt of payment.

YOU ARE RESPONSIBLE FOR AMOUNTS NOT COVERED BY YOUR INSURANCE

***INITIALS*_____**

PAYMENT POLICY

Unless your insurance has been 100% verified, you are responsible for charges accrued. Your co-pay, co-insurance, and deductible are due at the time of service rendered *OR* a minimum of a **$25 payment is collected *EACH VISIT*** (excluding Medicare, Worker's Compensation, and VA). You will receive a monthly statement which will show you the status of your account. If you have any questions or would like to set-up an individualized payment plan, please speak our Office Manager (Tiffany).

***INITIALS*_____**

WORKER'S COMPENSATION *(if applicable)*

Worker's Compensation benefits will be verified, however, this does not guarantee payment. In the event of denial, this account will become *YOUR RESPONSIBILITY*.

***INITIALS*_____**

MEDICAID *(if applicable)*

Medicaid coverage is associated with a co-pay in the amount of **($2.45)** and will be collected at *EACH VISIT*.

***INITIALS*_____**

CANCELLATION POLICY

Core 307 PT strives to provided individualized and attentive care, and our schedule is set accordingly to allow for one-on-one treatment. We would appreciate and respect a 24 HOUR NOTICE PRIOR TO YOUR APPOINTMENT or we reserve the right to assess a **($25)** cancellation fee.

***INITIALS*_____**

"NO SHOW" POLICY

Failure to show up or give notice for a scheduled appointment, "NO SHOW," without adequate (24 hours) notice will result in a **($25)** no show fee. Two (2) CONSECUTIVE no show appointments will result in cancellation of all future scheduled appointments.

***INITIALS*_____**

Authorized Signature:_____Date:_____