Patient Attendance and Financial Policy

Thank you for choosing Britt Zink Physical Therapy Services as your healthcare provider. We are committed to building a successful provider-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e. name, address, phone numbers, insurance information, etc). Any information provided to our office may be used in proper care or collection by our office or by our business partners.

Co-pays

Co-payments must be paid on the date of service upon patient arrival for their appointment. In the case of a minor, the patient's accompanying adult, parent, or guardian is responsible for co-payment at the time of service. We accept cash, check or credit cards. Post-dated checks will not be accepted. We accept HSA cards.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are not a party of this contract, but we will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Referrals and Pre-authorizations

Certain health insurances (HMO, POS, etc.) require that you obtain a referral or prior authorization

from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if not obtained.

Self-pay Accounts

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. Full payment is expected at the time services are rendered. Liability cases will also be considered self-pay accounts. We do not accept attorney letters or contingency payments. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven.

Motor Vehicle Accident (MVA) and Third Party Billing

We do not do any third party billing. Our relationship is with you and not with the third party liability insurance (auto, homeowner, etc.) It is your responsibility to seek reimbursement from them. At your request, we will bill your liability insurance carrier for you. However, because liability coverage may be limited and lawsuits can go on for years, you must provide a copy of your private insurance card. At your request, we will submit a claim to your primary health insurance carrier. You may receive an accident questionnaire from them to be completed by you. If the questionnaire is not returned to your medical insurance company and/or we receive a denial on your claim, you will be responsible for payment in full.

Workers' Compensation

It is the patient's responsibility to provide our office staff with employer authorization/contact information regarding a workers' compensation claim. If the claim is denied by the workers' compensation insurance carrier, it then becomes the patient's responsibility. At your request, we will submit the claim to your primary medical insurance carrier with a copy of the workers' compensation insurance denial. If your primary medical insurance carrier's claim is denied, you will be responsible for payment in full.

<u>CANCELLATION OF APPOINTMENTS</u>

We work diligently to provide each of our patients with the highest quality of care while striving to accommodate to your schedule for your convenience.

Your consistent attendance is essential for your maximal recovery. Cancellations and no-shows negatively impact our ability to accommodate the scheduling needs of other patients. We ask for your cooperation with the following:

If it is necessary to cancel a scheduled appointment, we require **at least 24 hours advance notice.**

Late Cancellations: A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24 hour advance notice.

No-shows: a no-show is when a patient misses an appointment with no notice or shows up too late to the appointment to be seen. If you arrive late to your appointment, and more than 10 minutes of your scheduled appointment time has passed, we may ask you to reschedule your appointment.

A **$50.00 fee** will be billed to your account for late cancellations and for no-shows.

Repeatedly missing visits jeopardises your care. For this reason ***after an ESTABLISHED patient has three (3) late cancellations and/or no-shows or a NEW PATIENT has one (1) cancellation or no-show, they will be discharged from the practice.***

Workers compensation managers are required to be notified of all missed appointments.

We understand that emergency situations may arise, and will take these instances into account.

Returned Checks

The charge for a returned check is $40 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Minors

The parent(s) or guardian(s) is responsible for full payment and will receive the billing statements. A signed release to treat may be required for unaccompanied minors. A minor is defined as a patient under 18 years of age.

Information Sharing

If patient is married at the time that service is provided, both patient and spouse are legally responsible for the charges. If balance is outstanding, Britt Zink Physical Therapy Services LLC may contact patient or spouse to discuss payment options. Business partners of Britt Zink Physical Therapy Services LLC also comply with this policy.

Outstanding Balance Policy

It is our office policy that all past due accounts be sent two statements. A 1.5% or $10.00 minimum late fee will be assessed on accounts 60 days or over. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice. In the event that an account reaches collections status, additional fees may be assessed.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections and all associated fees including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

I have read and understand the patient financial policy and cancellation/no show policy and agree to its terms and conditions.

____ Date: ________________________

Signature of patient or applicable responsible party