ENCORE
PHYSICAL THERAPY

# Financial Policy

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

We will request a photocopy of the front and back of your insurance identification cards, as well as a photo ID (Driver license) Please update your card with any additional information your insurance company provides which will facilitate the submissions of claims on your behalf, including name, address and phone numbers. *It is your responsibility to inform us of any changes to your policy.* We will bill your insurance company on your behalf as a courtesy.

**Co-Payments:** As required by your insurance, co-pays are due and payable at the time of service. We will bill you for any co-insurance or other balance due after we have been paid by your insurance company. If there is a denial for payment, we will notify you.

**Missed Appointments:** ***A 24 hour cancellation notice is required for all scheduled appointments.*** Patients who do not show up for an appointment, and do not call to cancel have impacted other patient's ability to obtain timely medical care. ***We reserve the right to charge a $50 fee for missed appointments or same day cancellations.***

**Insurance:** We will gladly bill and accept payment from your health insurance plan. Your co-payment is expected at the time of service. We accept cash, checks, MasterCard and Visa. *Any amounts not covered by your insurance carrier including co-insurance and deductible is your responsibility.*

We find communication between our office and our patients helps us to succeed in providing the best care. We try our very best to verify each patient's insurance/benefits as a courtesy, however it is ultimately the patient's responsibility to contact their insurance carrier to verify their physical therapy benefits. Please advise us if your insurance company has pre-certification and/or prior authorization requirements and/or policy restrictions and limitations.

I have reviewed, understand, and agree to comply with this policy. I hereby authorize Encore Physical Therapy to submit claims to my insurance carrier. I hereby authorize direct payment of benefits, otherwise payable to me, to be made payable to Encore Physical Therapy. I understand I will be responsible for payment of any amounts not covered by my insurance carrier, including, but not limited to, co-payments, co-insurance and deductibles.

**Please initial the highlighted boxes and sign below.**

Signature:_____ Date:_____