Financial Policy

At Encore, we are committed to providing you with the best possible care. In order to do that, the following policies have been implemented to ensure we can maintain our professional relationship with you. If there are any questions regarding the following, please ask our office staff.

Insurance

During your first visit, we will request a photocopy of the front and back of your health insurance card(s) and a photo ID. We will use this information to bill your insurance. **It is your responsibility to inform us of any changes to your insurance or personal information in a timely manner.** *Failure to report changes will result in delayed claims processing and delayed billing*

As a courtesy, we will verify your insurance benefits at the start of your care. This information will be provided to you on a separate form. ***Any amount not covered by your insurance will be your responsibility.*** **Your portion of the cost will be collected at the time of appointment based on a Good Faith Estimate. This is an estimate, you may receive an additional bill if there are discrepancies between the estimate and your insurance company.** Statements are mailed once a month. Payments can be made via check or credit card.

If you are not using insurance, we have a flat rate of $125 for a 45 minute session.

No Show and Late Cancel Policy

If you need to cancel your appointment, we require 24 hours notice. Failure to provide 24 hours notice or if you do not show up for your appointment, a $50 fee will be charged to your account. A $75 fee will be charged for each additional late cancellation/no show. We reserve the right to not reschedule if you are not showing up to your appointments.

I have reviewed, understand, and agree to comply with the above Financial Policy. I hereby authorize Encore Physical Therapy to submit claims to my insurance carrier if applicable and understand I will be responsible for payment of any amounts not covered by my insurance carrier, including but not limited to, co-payments, coinsurance, and deductibles.

Patient/Legal Guardian Signature:_____

Printed Name: _____ Date: _____