



**PHYSICAL THERAPY**

## **Financial/No Show Policies**

### **Financial Policy**

I agree to pay for all services rendered. I agree to pay any and all amounts that my insurance company applies to any unmet deductible. If my insurance company requires a co-payment, I agree to pay it at the time of each appointment. If my insurance pays on a percentage basis, I agree to pay an average amount per visit based on what my percentage is. This is to be negotiated and agreed upon with the office manager.

I understand that I will be fully responsible for any services deemed as non-covered or denied by my insurance company. I agree to pay for any medical supplies that are not covered by my insurance, under my policy. I recognize and accept complete financial responsibility for any balance remaining after the payment of correct benefits by an insurance company.

If my insurance company is out-of-network with Fit Physical Therapy and/or if there is a limit on the number of units per visit, I agree to pay the difference between what is paid by my insurance company and the services rendered by Fit Physical Therapy.

I assign insurance benefits for all services rendered by permitting payment directly to FIT Physical Therapy for services rendered.

Payment can be made in the form of cash, check, and/or credit card (Visa, MasterCard). There will be a \$25.00 per check charge for all returned checks.

### **No Show Policy**

I understand that I will be charged a \$30.00 fee if I fail to keep an appointment without calling to cancel or reschedule 24 hours in advance, unless in case of emergency or illness. This missed visit will be considered a "No Show" and the \$30.00 no show fee will be my responsibility. My insurance will not be billed.

I certify that I am 18 years of age and/or the legal guardian/guarantor. I understand and accept full financial responsibility for the patient listed below.

Printed Name of Patient: \_\_\_\_\_

Signature of Patient and/or Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_