PHYSICAL THERAPY

Financial Policy

I agree to pay for all the 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 understand to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that is it my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree it is and shall remain my responsibility to pay all amounts as set forth. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 33.33% of the principal amount(s) owing as allowed by Utah and Nevada Code. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

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 per check charge for all returned checks.

No Show Policy

I understand that my therapy appointment time is reserved specifically for me. Failure to arrive on time, or to keep an appointment without appropriate notice will result in a nonrefundable $35 fee. I understand that the fee is solely my responsibility and further appointments may not be scheduled until the fee is paid.

_____ (please initial)

** I certify that I am 18 years of age and/or 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: _____