FINANCIAL INFORMATION FORM

***Note: it is your responsibility to provide a copy of your current insurance card(s)**

Benefits & Eligibility:

As a courtesy, P**ierce Physical Therapy** will verify your physical therapy benefits and eligibility with your insurance company. Please be advised verification of benefits is not a guarantee of payment. **We strongly advise that you contact your health insurance directly to verify this information for your benefit. Pierce Physical Therapy** will not accept financial responsibility for misleading or incorrect information given to us by you or your health insurance company. It is your responsibility as the patient to be aware of the physical therapy limitations of your health insurance policy. **Please note: certain insurance companies regulate the total number of visits, so any previous treatments may count toward your yearly total visits allowed for physical therapy.** You are financially responsible for any services rendered after you have exhausted your therapy limitations.

Deductibles & Co-pays:

Physical therapy treatments may be subject to a deductible, co-pays, and co-insurance. Co-pays, deductibles, and con-insurance will vary depending upon your specific insurance policy. You are financially responsible for any co-pays or deductibles dictated by your policy. Benefits or co-pays quoted may change when claims are processed due to individual insurance policies. If this applies, please note deductibles reset to their full amount on a specific date each year. **Please note: if the deductible has not been met, the physical therapy benefit will be applied and be the patient's responsibility. This will continue until the deductible on the policy has been satisfied.** You will be expected to make required payments at the time of each treatment session. We accept cash, personal check, visa, MasterCard. We will charge a $25.00 fee for any returned check.

Out of network benefits:

If P**ierce Physical Therapy** is not a participating provider with your health insurance, we will bill your insurance company as a courtesy if the insurance plan includes out of network benefits. If treatment is not considered an emergency, your insurance company may not pay for physical therapy treatment. Please note the benefit will not be paid at a full network benefit, therefore you will be responsible for any amount remaining deemed by your insurance company.

Motor Vehicle Accidents:

As a courtesy, **Pierce Physical Therapy** will bill the motor vehicle insurance if information is provided and coverage can be verified. You will be asked to sign a lien of payment for services rendered. If motor vehicle insurance information cannot be obtained and verified, your health insurance will be billed for services rendered. If neither of the above applies, you will be considered a private pay patient. **Please note: any monies paid by your health insurance to our office for services rendered must be repaid to your health insurance company by you if a monetary settlement is reached. If a settlement is reached and the health insurance company is not repaid by you, any requested reimbursement from the health insurance company to our office, will be deemed patient's responsibility.**

In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principle amount owing as well as all reasonable costs associated with the collection of this debt. This includes, but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associate with the recovery of this debt. Interest may be charged at a rate of 1.5% per month for unpaid balances over 90 days.

- I authorize that the payment of my insurance benefits be made directly to **Pierce Physical Therapy** for all services rendered; if I am paid directly I will promptly pay **Pierce Physical** T**herapy** all monies paid to me.
- I understand that all payments designated as "the patient's responsibility" such as co-insurance and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by my insurer by the statement due date.
- I do hereby consent to such treatment by the authorized personnel of P**ierce Physical** T**herapy** as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

By signing below, you are stating that you fully understand and acknowledge the above information, and that you agree to take full financial responsibility for all services rendered at Pierce Physical Therapy.

_____ _____

Patient Name (print) Date

_____ _____

Signature of Patient/Legal Guardian Relationship to patient