



## Financial Responsibility

Hands On Physical Therapy will bill all insurances. Insurance has the right deny any claim that we submit, claims are submitted daily. Patients are responsible for any information requested by their insurance company. Failure to do so may result in denial of payment.

It is our policy to send out a statement when balance is due, balance can and will change on each statement as insurance continues to pay or direct balances toward deductible. Statements will be sent our every 30 days; balances must be paid off before treatment can begin, if patient was previously seen at our facility.

Patients who are minors, billing therapy under their parents/guardians insurance must pay co-pays and deductibles at the time of service. We will **not** bill the parents/guardians for balance due, unless guarantee of payment is made by the parent/guardian. If patient is unaccompanied to their therapy session patient should have a form of payment with them. If no payment is given at the time of service we have the right to suspend therapy until payment has been made, once payment is made therapy will continue.

Patients will be notified of their benefits the first day of their appointment, unless circumstances prevent this. These benefits are not a guarantee of payment, they are interpretation only, benefits are subject to change at your insurance's discretion, not ours.

Patients are responsible for co-pays, deductibles and any visits that may be denied. Co-pays and deductibles are to be paid at the time of service. If you fail to make payment we will suspend therapy until payment is made, once paid therapy will restart.

Patient can make payment arrangements towards account balances. Office manager must approve all payment arrangements. If patient does not make payments towards account balance we will send the first installment of three warning letters. The final and third letter will be patient's last warning and will consist of legal action of a collections agency.

I understand the policy I have read, I here by give authorization to release my medical information to my insurance company to process claims and in order to receive payment under my policy.

Sign \_\_\_\_\_

Date \_\_\_\_\_

