FINANCIAL POLICY

(*If you choose not to read this –it is still in effect)*

Our fees are comparable to the usual and customary charges of other physical therapists in our area. These customary charges are based upon cost, time and skill involved.

Patients without insurance coverage are requested to pay their charges at the time service is provided. Patients with insurance coverage are responsible for co-pays at the time of visit, plus the estimated charges not covered by the insurance company. If an estimate of charges is needed, ask the physical therapist directly before care is given, he will know what care will be necessary in your unique case.

Accounts with balances over 60 days will be subject to an interest charge of 1.33% per month. Invoices will be sent once a month at the beginning of each month on accounts with charges not covered by insurance. Invoiced accounts that remain unpaid by the 15th of the month will be subject to a $5 late charge. Accounts with returned checks will be charged a $25 returned check fee. Payment plans are available.

OUR POLICY ON INSURANCE

Please remember that insurance estimates are based on information provided by your insurance company. The amount of insurance coverage estimated is an estimate only, and may not reflect what your insurance carrier will *actually* pay under your policy.

We will gladly discuss your treatment with you and answer any questions relating to your insurance to the best of our ability. However, you must realize that:

Your insurance is a contract between you and your insurance carrier, and may involve your employer. We are not a party of that contract.

1. Not every service we provide may be a benefit with all insurance contracts. Some insurance companies are selective in what services they cover.
2. Services may be provided on the assumption that the charges will be paid by the insurance company; however, **the patient understands that they are ultimately responsible for treatment costs, not covered by insurance.**
3. As a courtesy, advance notice for missed or rescheduled appointments is required. There will be a $30.00 fee in the event you miss an appointment without giving a 24-hour notice. You will be *personally* responsible for this fee - it will NOT be billed to insurance.

If you have paid on your account, and an insurance payment results in a credit balance, a refund will promptly be sent to you.

PATIENT AGREEMENT:

I have read and fully understand this document, and I am voluntarily signing this document. I hereby assign the insurance benefits that are otherwise payable under my insurance policy to Pinnacle Physical Therapy for services provided, and direct that insurance payments be made directly to them. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not I have insurance. I further authorize Pinnacle Physical Therapy to release all information necessary to secure payment.

Patient or Guardian Signature	Patient or Guardian Printed Name	Date

4025 Cherry Avenue NE ▪ Keizer, OR 97303 ▪ 503-390-9009 ▪ Fax 503-393-0834
210 W Ellendale Avenue Suite 100 ▪ Dallas, OR 97338 ▪ 503-623-2433 ▪ Fax 503-623-2196