ProfessionalTherapyAssociates
Do life better.

PATIENT FINANCIAL POLICIES

TO OUR VALUED PATIENTS:
We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to do this, we need your assistance and understanding of our payment policy. Also note, our company complies with all HIPAA Privacy Practices. By signing this form, you acknowledge that you have been offered and/or have received a list of these practices.

Please read carefully:

1. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. You will be responsible for paying for your visits until your deductible is met. Once your deductible is met, you will be responsible for your co-pay or co-insurance.
2. Our fees are considered to fall within the acceptable range by most companies, and are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage of U.C.R. "U.C.R." is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees.
3. Not all services are covered in all contracts. Some insurance companies select certain services they will not cover. *These particular services, if any, are your responsibility.* We will make our best attempts to inform you as soon as possible if/when we encounter services your insurance company does not cover. If your insurance company does not cover supplies, you will be responsible for payment of such, should you choose to receive them.
4. The estimate provided at time of service is not an exact calculation of your actual costs and does not reflect all of the terms, conditions, limitations, and exclusions that may apply to your coverage. Your actual costs will vary depending upon the specifics of your benefit plan and the particular services and supplies you receive.
5. If this injury is work related and a Workers Compensation claim has been initiated then we require, on your initial visit, that you provide us with a claim # to ensure payment of the account.
6. For liability cases, where another party is responsible, you need to provide us with all the billing information. If you have an attorney, please provide this information on the registration form. It is our clinic's policy that a letter of protection must be received from your attorney within the first 2 weeks of your treatment. Without this letter, you become responsible for the account in full.
7. Our office requires **a 24-hour notice for cancellation of appointments;** you can call and leave a message on the answering machine if needed. We realize conflicts with work, other activities, or unexpected illness may require you to call and reschedule, however, there may be a $35.00 charge for a missed appointment without notification to the office.
8. Payment is due at time of service unless you have signed a monthly payment contract through our Billing Office. Any account that goes beyond our 6 month maximum allowance time for payment in full will be assessed a 2% finance charge per month (minimum $.50/mth) against any unpaid balance. Payments made on account will be applied to the oldest outstanding balance first.
9. We reserve the right to terminate services if payments are not made in a timely fashion.

Again, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. Should you have encounter problems making payments on time, we encourage you to contact us promptly for assistance in setting up a payment plan. If we do not receive payment from you according to agreement and/or the arranged payment plan notice we sent to you, you agree to be responsible for any expenses incurred in collecting patient's account, including all fees, court costs, attorney fees and all other collection related expenses. By signing below, patient/responsible party acknowledges that he/she has read, understands and hereby accepts the above obligations and agreements.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

I have read the above policies and agree.

Patient Name: **Signature:** **Date:**

Information below is *required for treatment of a minor or a patient who does not have their own power of attorney.*

*******PERSON SIGNING BELOW MUST FILL OUT ATTACHED GUARANTOR INFORMATION**********

Name of Parent or Legal Guardian: **Signature:**

Date:____________________________________

PTA
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GUARANTOR INFORMATION

IF YOU ARE SIGNING OUR FINANCIAL POLICY OR INTAKE FORM AS THE PERSON OR LEGAL GUARDIAN OF THE PATIENT LISTED ON THIS FORM, WE MUST HAVE THE FOLLOWING INFORMATION:

Name of Parent or Legal Guardian: ______________________________

Male Female DOB:___________________________ SSN:___________________________

Mailing Address: ______________ City/State: ______________ Zip: ______________

Phone: Home: ______________ Work: ______________ Cell: ______________

Email Address: ______________________________

Place of Employment: ______________ Occupation: ______________

Employment Address: ______________ City/State: ______________ Zip: ______________