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HAUSMANN
PHYSICAL THERAPY

FINANCIAL POLICY AND STATEMENT OF RESPONSIBILITY

It is the patient and/or guardians who contract for our services and it is the patients and/or guardians to whom we look for payment. While we will assist you in any way we can to obtain payment of benefits from your insurance company, we will not accept responsibility for payment or denial of benefits.

FOR PATIENTS WITH INSURANCE: We will bill most insurance carriers for you when proper paperwork including insurance cards, is provided to us. We will also bill most secondary insurance companies for you. Co-payments are due at the time of service.

MEDICARE PATIENTS: We will bill Medicare for you. We will also bill secondary insurance carriers for you. All co-payments are due and payable at the time service is provided.

LIABILITY CLAIMS & AUTO ACCIDENTS: We will file insurance claims for services related to an auto accident or third party liability. We will accept health insurance payments after auto or liability has paid.

WORKERS' COMPENSATION: If your injury is work related, we will need the case number, carrier name, and information prior to your visit in order to bill the Workers' Compensation insurance company. The patient is ultimately responsible for all professional fees if a Workers' Compensation claim is denied.

SELF-PAYMENT ACCOUNTS: We ask that you make payment at the time of each visit. We are happy to accept payment by cash, check, or credit card.

COLLECTIONS: If your account reaches 90 days past due and you have not contacted us to make payment arrangements, your account will be turned over to a collections agency.

For the convenience of our patients, we do accept VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS and CARE CREDIT.

INTEREST AT 16% WILL BE CHARGED ON ALL PATIENT BALANCES AFTER 60 DAYS. Initial_____

HAUSMANN PHYSICAL THERAPY WILL NOT CARRY ANY BALANCE OVER 90 DAYS. Initial_____

I have read, understand and agree to the above financial policy for payment of professional fees. I understand the patient is ultimately responsible for all professional fees.

Patient or Guardian Signature: _____ **Date: _____**