Valley Physical Therapy

Insurance Information

As a courtesy we have contacted your insurance company _____ and they provided us with the following benefit information. ***This information is not a guarantee of coverage or payment, payment is determined at the time a claim is received.*** *(Valley Physical Therapy is not responsible for the accuracy of the following benefit information.)*

Deductible amount: $_____ Deductible balance remaining: $_____

Co-payment/Co-insurance amount: $_____ per visit.

Benefit limitation: _____

Your insurance policy is a contract between you and your insurance carrier. You are responsible for ensuring that the services or products you receive are covered. If your insurance carrier requires pre-authorization or limits your physical therapy benefit in some way (i.e. number of visits, monetary limit) you are responsible for keeping track of this limitation. If you exceed the benefit limitation or the services/products are not covered for any reason you will be responsible for the charges incurred. _____ **(Initials)**

Valley Physical Therapy will bill your insurance company as a courtesy. Should payment be denied by your insurance carrier for any reason the full balance shall be your responsibility and due immediately. You are responsible for informing us of any changes in your insurance coverage, address or phone number. If we are not informed of such changes and this omission results in payment denial, you will be responsible for payment in full. _____ **(Initials)**

We do accept assignment with a variety of insurance carriers. If your insurance carrier requires a co-payment, only pays a percentage/portion of the charges, or you have an unsatisfied deductible, Valley Physical Therapy expects you to pay your portion of the charges at the time of service. Valley Physical Therapy does not offer statement billing on balances due. _____ **(Initials)**

We understand your need for physical therapy may not have been planned, so your ability to pay immediately may be difficult. To assist you we accept MasterCard, Visa, American Express, cash, checks, and money orders. _____ **(Initials)**

It is Valley Physical Therapy's policy to have a current credit card number on file for all patients.

Card Type: MC Visa AMEX Card number: _____

Expiration Date: _____ Billing zip code:_____

Accounts with balances exceeding 90 days will be considered delinquent and will be transferred to an outside Collection Agency. There will be a $25.00 fee assessed for collection processing. You will then be responsible to make payment directly to that agency. _____ **(Initials)**

MY SIGNATURE BELOW INDICATES THAT I HAVE READ AND UNDERSTAND THE BILLING POLICIES OF VALLEY PHYSICAL THERAPY. I AUTHORIZE VALLEY PHYSICAL THERAPY TO RELEASE TO MY INSURANCE CARRIER AND AUTHORIZED AGENTS ANY INFORMATION NEEDED TO DETERMINE THE BENEFITS PAYABLE UNDER MY COVERAGE. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF AN ORIGINAL.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICAL BENEFITS BE MADE ON MY BEHALF TO VALLEY PHYSICAL THERAPY FOR SERVICES GIVEN TO ME BY ITS STAFF.

_____ _____

Patient's name and ***phone number*** (please print) Name of Guarantor (if different than patient)

_____ _____

Patient/Guarantor Signature Date