



### Our Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you read and sign prior to any treatment. Please let us know if you have any questions or concerns. Our office staff will be happy to provide you with more information regarding payment options.

#### PAYMENT OPTIONS

Payment of co-pays and/or any unmet deductible is due at time of service. If you have a large deductible we can work a payment plan out for you. We accept cash, checks, or most major credit cards.

#### *Regarding Insurance*

We do accept assignment of insurance benefits and will be happy to file claims on your behalf. The balance is your responsibility regardless of whether your insurance company pays or not. We cannot bill your insurance company unless you give us your COMPLETE AND CURRENT insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is your responsibility to ensure they live up to the terms of that contract. If the insurance company requests information from you, it is your responsibility to send it to them. If it is not received, your claims will be denied and you will be responsible for the amount of your bill. If the insurance company has not made full payment within 120 days we will bill you the entire amount that is owed. If you prefer to file insurance claims yourself, you may pay your account in full using the above methods. We will assist you by providing all appropriate information your insurance company will require.

Please be aware that some of the services provided may not be considered necessary under the terms of your particular plan. Please be assured that our practice will provide only those services which your doctor and physical therapist determine are necessary for you.

#### PATIENT PAYMENT GUARANTEE

Our practice is committed to providing the best treatment for our patients and our charges reflect what is usual and customary for our area. Please remember that you are responsible for all charges and expenses of Peak Performance Physical Therapy, of every kind and description, for services, facilities and any other thing supplied or furnished the patient. If the account goes to our outside collection agency, the patient agrees to pay any additional costs in obtaining the amount due.

I \_\_\_\_\_, have read and understand the above financial policy and I agree to abide by this policy.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Co-Responsible Party

\_\_\_\_\_  
Date