New Paradigm physical therapy

Financial Policy And Agreement

Thank you for choosing New Paradigm Physical Therapy for your physical therapy needs. This office is committed to providing the highest quality physical therapy care. To avoid any misunderstanding, the following is an explanation of our Financial Policy and Agreement which we ask you to read and sign prior to any evaluation or treatment.

❑ HEALTH INSURANCE PATIENTS

❑ PRIVATE PAY/NO INSURANCE PATIENTS

1. Patient is responsible for knowing their Physical Therapy Insurance Benefits, including if Pre-Authorization or a PCP Referral is required by their Insurance in order to receive benefits.
2. Your Insurance is a CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY, as a courtesy this office will submit bills to your Health Insurance carrier.
3. After 60 days, there will be a finance charge of 1.75% per month (21% annual) posted to your account.
4. A $20.00 fee will be charged on all returned checks and missed appointments not cancelled 24 hours in advance.
5. Payments of all insurance co-pays and deductibles are due at the time services are rendered.
6. I will provide all insurance policy information and changes to NPPT. If my insurance information is not supplied within one week, I will pay all charges.
7. I understand that if my insurance benefits are maxed or denied for not medically necessary I will be billed a private pay fee that is due at the time services are rendered.

_____ _____

Patient Signature or Responsible Party Date

By signing above, I acknowledge receipt of this Financial Policy and Agreement and agree to abide by its terms. I agree to pay any collection costs and/or reasonable attorney's fee if any delinquent balance is referred to an agency or attorney for collection or suit.

❑ AUTO AND WORKERS COMPENSATION PATIENTS

1. I understand that I must furnish NPPT with my No-fault Auto Insurance/Workers Compensation information, within one week of my first visit or personally pay for all incurred charges. Information will include:
   a. My No-Fault auto Carrier's/Workers compensation Name, Address, Claim #, Adjustor's Name and Telephone Number.
2. Your Auto Insurance/Workers Compensation policy is a CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY as a courtesy this office will submit bills weekly to your Auto Insurance/Workers Compensation carrier. If your Auto Insurance/Workers Compensation has not paid the billed charges in full within 60 days, the outstanding balance MUST BE PAID BY YOU.
3. I understand that when my Auto Insurance PIP (Personal Injury Protection)/Workers Compensation is exhausted I have two options:

Bill my Health Insurance. I understand if this insurance information is not given, I will be personally responsible for full payment of all charges.
Private Pay which I understand is due on the day of my treatment.
A $20.00 fee will be charged on all returned checks and missed appointments not cancelled 24 hours in advance.

_____ _____

Patient Signature or Responsible Party Date

By signing above, I acknowledge receipt of this Financial Policy and Agreement and agree to abide by its terms. I agree to pay any collection costs and/or reasonable attorney's fee if any delinquent balance is referred to an agency or attorney for collection or suit.