

<b>ADVANCED THERAPY AND SPORTS MEDICINE</b>	1514 K96 Hwy.	Great Bend, KS 67530
<b>PROGRESSIVE PHYSICAL THERAPY</b>	2209 Canterbury	Hays, KS 67601
<b>PROGRESSIVE THERAPY AND SPORTS MEDICINE</b>	117 West 6 <sup>th</sup>	Larned, KS 67550

Thank you for choosing us for your therapy needs. We are committed to make your experience at our clinics successful.

## REVIEW YOUR INSURANCE POLICY AND “SCHEDULE OF BENEFITS”

We urge you to review your insurance policy’s “Schedule of Benefits”. It will help you understand the agreement you have with your insurance company . You should call your insurance company with any specific questions related to your policy as it pertains to outpatient physical therapy benefits. You need to verify and understand your policy’s deductible, co-payment, coinsurance, visit limitations, effective annual calendar renewal date, and any pre-authorization requirements. **As a courtesy, we will also verify your coverage, but we will not guarantee the accuracy of the information we receive.** Your insurance company states it is a *description of benefits*, not a *guarantee of payment*. Your insurance policy is a contract between you and your insurance company. **You are responsible to know your level of coverage, and you are ultimately responsible for the full payment of your bill.**

## INSURANCE INFORMATION

We need complete and accurate information about your policy. We will submit claims to your health insurance company for you. You are responsible for payment of any deductible, co-pay and co-insurance as determined by your contract with your insurance company. You are responsible for any amount or any services not covered by your insurer. If your deductible has not been met, we will ask you to make payments toward the deductible while you are receiving treatment.

It is your responsibility to inform us of any and all changes of insurance coverage during the course of treatment. Failure to do so may result in denial of coverage by your insurance company.

## IN-NETWORK

If we are currently a contracted provider with your insurance company, we will bill them for you. We will accept the Preferred Provider maximum allowable charge determined by your insurance company. You are responsible for meeting the in-network deductible before your insurance will begin to reimburse for the services rendered. You are responsible for co-payments and/or co-insurance as described in your “Schedule of Benefits”. Co-pays and deductibles are due at the time of service. You must have a current insurance card with the billing address and phone number listed.

## OUT-OF-NETWORK

You are responsible for meeting the out-of-network deductible before your insurance will begin to reimburse for the services rendered. You are responsible for co-payments and coinsurance. You are also responsible for the difference between billed charges and your insurance company’s maximum allowable charges. Your out-of-network benefits for outpatient physical therapy will be clearly explained in your insurance policy’s “Schedule of Benefits”. We will submit claims for payment to your insurance company. If your deductible has not been met, payment for the initial evaluation and treatment will be due at the time of service.

## NO INSURANCE / SELF PAY

We will discount our standard fee schedule by 15% for this arrangement. **To be eligible for this discount, full payment must be received for the services rendered at the time of service.** Fee for service is exclusively a non-insurance financial arrangement. The fee for service arrangement is separate from the In-network and Out-of-network scenarios. Receipts given for services cannot be submitted to insurance for reimbursement.

## MEDICARE

We are a Medicare approved provider of outpatient physical therapy. There is a CAP limit of \$\_\_\_\_\_per calendar year for outpatient physical therapy. If you exceed the CAP limit, you will be responsible for payment of services after the CAP has been met.

If you are claiming worker’s compensation you must provide us with a copy of your personal insurance card in the event the worker’s compensation claim is denied. We will confirm your authorization with your case adjuster or case manager. If your claim is denied we will file the claims with your personal insurance policy. If your claim is denied by your personal insurance, you are responsible for the full payment of your bill.

**SECONDARY INSURANCE**

If you have secondary insurance you must present it at your initial visit. The same policies and responsibilities apply to the use of secondary insurance. You are responsible for the accuracy of the insurance information we use to submit the claim, and you are ultimately responsible for the full payment of your bill.

**AUTO, LIABILITY, OR INVOLVEMENT OF AN ATTORNEY**

You will need to supply us with the name, phone number, and address of the insurance company we will be billing for the services you receive. You must still provide us a copy of your personal insurance card. In the event your claims are denied, or benefits have been exhausted by the liability or auto insurance carrier we will file claims with your personal insurance. You will be responsible for any deductible, co-pay or coinsurance determined by your health insurance. If your health insurance denies the claim, you will be responsible for payment.

Attorney involvement does not guarantee payment of your account. Litigation can be lengthy, and settlements go directly to the patient. We will expect you to be responsible for payment of this account according to our Billing Procedures.

**MINORS**

Minors under the age of 18 need to be accompanied at their first visit by the parent or guardian to sign patient information and financial responsibility forms. The parent or guardian is responsible for full payment. If the parents are separated and both legally responsible for the child you must provide complete information from both parents. The parent or legal guardian that accompanies the minor patient to the clinic will have full responsibility for the payment should any dispute arise.

**BILLING PROCEDURES**

We bill your insurance as a courtesy to you. We bill most insurance on a weekly basis. Payments that are received from insurance are posted to your account, and adjustments taken according to contracted fee schedules for in network insurance. You are responsible for payment of these services once insurance has paid. If your insurance does not pay in a timely manner, you are responsible for payment of the services.

Patient statements are mailed out monthly, showing your services and any insurance payments and or adjustments posted to your account. If insurance has paid or processed services a patient balance will show at the bottom of the statement and this amount is due by you. We accept cash, check, or Mastercard and Visa if you choose to pay your account in this manner. (A fee of \$35.00 will be charged on all returned checks.)

**Our policy is to have accounts paid in full no more than 90 days after the final insurance payment.** If you are not able to meet this obligation, we will set up a payment plan for you. A minimum payment of \$50.00 per month is required. *Interest of 1.5% will be charged on unpaid balances that are in excess of 6 months old.*

**COLLECTIONS**

We will work with you to avoid sending your account to collections. In the event of default on your account, your account will be turned over to an attorney for collection. You will be responsible for the unpaid balance *and* additional filing fees, and interest as determined by the attorney.

X

\_\_\_\_\_  
**Patient / Guardian / Responsible Party**

\_\_\_\_\_  
**Date**

Your signature indicates you have read this policy and agree to the terms of your financial obligation. A copy of this policy will be given to you upon your request.

