Patient Financial Responsibility Agreement

Patients are responsible for copayments, deductibles, coinsurance and non-covered services by the insurance company. The fee for physical therapy services is set by your insurance company.

Copayments are due at the time services are rendered.

For patients that have not met the annual **deductible** or have a **co-insurance**, we are requesting a pre-payment at each visit. You will be billed for any remaining balance after your claim processes by your insurance company.

Patients that have **Medicare or a Medicare Advantage plan**, iontophoresis may not be covered. We will provide you with an Advance Beneficiary Notice to sign and you will be responsible for the billed amount.

Payment for **non-covered services** or **supplies** are due at the time of service or when the supply is received. A partial list of non-covered supplies are as follows;

Ionto pads - $6.00 each
Splints – that are not covered by insurance
Therabands/Minibands
Theraputty
Lumbar rolls
Ice packs
Biofreeze

Credit Card Fee – There will be a 3% fee on credit cards.

Cancel / No Show Policy – If you cancel less than 24 business hours or no show for your appointment, you will be charged a $40.00 fee.

Financial Agreement
I understand that any charges for services not covered by my insurance carrier are my responsibility to pay in full. If my bill goes to a collection agency or into litigation, I will be responsible for collection fees, court costs and any reasonable attorney fees. I agree to be responsible for any bank charges for checks returned due to insufficient funds. I will keep this office informed of any changes in my health insurance benefits. All payments due will be made on a per-visit basis. I hereby authorize payment directly to Linden Oaks Physical Therapy, PLLC of the insurance benefits otherwise payable to me. I understand that I am financially responsible for any itemized charges not covered by this assignment of benefits.

Release of Medical Information
I hereby authorize Linden Oaks Physical Therapy to obtain any medical records related to the condition for which I am being treated. I consent to the release of any medical records (PHI) regarding my treatment that is required by my insurance company to obtain payment or to my referring physician.

HIPAA Privacy Statement
I have been offered a copy of Linden Oaks Physical Therapy's Privacy Policy and have been given information about the location of the agreement in the office.
I authorize Linden Oaks Physical Therapy to discuss my protected health information (PHI) and appointments with the following person:
Name _____ Relationship _____ Restrictions _____

I have read and agree to the financial agreement, release of medicals and HIPAA privacy statement above;

_____ _____ _____
Patient Name (printed) Signature Date