PRO·MOTION
PHYSICAL THERAPY

FINANCIAL POLICY

We are pleased to have you as our patient, and we are committed to providing you with our best professional care. It is our goal to maintain a healthy relationship with our patients. This policy is intended to educate and clarify the responsibilities of the patient, your insurance, and our office in processing your claims and payments.

PATIENT RESPONSIBILITY: Patients are required to pay all co-pay and deductible amounts at the time of service. Patients are also responsible for any and all remaining balances due after insurance. Pro-Motion Physical Therapy billing staff will make every effort to bill a patient's insurance and will ensure that claims are promptly and correctly processed. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply in a timely manner with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim.

FORMS OF PAYMENT: We accept Cash, Checks, Visa, Master Card and Discover

PAYMENT PLANS: Patients are encouraged to pay outstanding balances in full, however payment plans are available. To set up a payment plan ask to speak with someone in our Billing Department or you may contact the Billing Department at (815) 521-4400.

SELF-PAY PATIENTS: Payment in full is required at the time of service for patients that do not have insurance coverage or for those patients that do not present their insurance card at the time of appointment.

REFERRALS: If your insurance plan requires a referral from a primary care physician it is YOUR responsibility to obtain the referral prior to your appointment and to have it with you at the time of appointment. If you do not have your referral, **you may have to reschedule your appointment.**

MEDICARE: Patients will be responsible for their yearly Medicare deductible (if not previously met) and the 20% coinsurance in those cases where patient does not have a Medicare secondary insurance. The Billing Office, as a courtesy to the customer, will bill insurance secondary to Medicare. If secondary insurance payments are not received within 60 days, the patient will be requested to pay the unpaid coinsurance in full.

SECONDARY & TERTIARY INSURANCES: The Billing Office, as a courtesy to the customer, will bill a patient's secondary Insurance. After 30 days, if the secondary carrier does not pay the outstanding balance, you will become financially responsible for the balance. If you need to make payment arrangements our Business Office requires patients to enter into a Payment Agreement, that once accepted by Pro Motion Physical Therapy will outline the terms and conditions under which the customer agrees to pay.

WORKERS COMPENSATION: The Work Comp Coordinator will attempt to obtain approval for patients requesting an appointment when injuries are due to a work related incident prior to scheduling an appointment. If prior approval is not obtained, the patient will be responsible for all charges for services rendered.

Workers Compensation/Motor Vehicle Claims/Personal Injury: If you are a **liability patient you must provide the following before being seen by a physical therapist:** Claim Number, insurance company name and address, date of injury, employers name and address, and attorney name, phone number and case number. If your claim is denied, then you will be responsible for providing any secondary insurance information and ultimately for payment. If your claim is in litigation, you are responsible for payment. According to the State of Illinois Department of Labor and Industry, we have the authority to bill the patient directly for any denied claims. Upon denial, please provide us with your private insurance information, or you may pay in full.

TREATMENT OF MINOR CHILDREN: A parent or legal guardian must accompany patients who are minors. Often the person responsible for the children's doctor bills is unclear. **In our office, the parent who brings the child in and requests treatment is the parent who is responsible for all fees incurred.** Therefore, if you brought the child in today, we ask that you provide us with your home address and phone number for billing purposes.

PAST DUE BALANCES: If you have any outstanding balances and you have been billed more than once without payment, you may be required to reschedule your appointment. A past due balance is any amount owed from a prior visit where insurance is not pending, the account has been sent to collections or an insurance payment has not been received by Pro-Motion Physical Therapy within 60 days. **Accounts with outstanding balances greater than 60 days will incur a $15 late fee per month that said account remains outstanding. Balances on accounts with payment plans where payments conform to the plan are not considered past due balances.**

I understand that if payment for services is denied for any reason by my insurance company that I am fully responsible for payment. In the event that this account is not paid, I understand that I will be responsible for attorney fees, court cost and all costs of collection. Venue for any collection action shall be in Grundy County, Illinois. I have read and understand this authorization. It is also understood that by signing this form permission is given to any agents or assignees of said collection agency to contact the patient and/or responsible party at any telephone number listed on the patient registration form. Any account that is referred to a collection agency will be required to be paid in full, as well as the collection agency fee, all attorney fees and court cost incurred by the creditor, before scheduling an appointment for a new problem**.**

RETURNED CHECK FEE-. A **$30.00** charge will be added to your account **for any check returned** by your bank for any reason.

MISSED OR CANCELLED APPOINTMENTS: **If you are unable to keep your appointment, you must call our office 24 hours before your appointment to cancel or reschedule.** Failure to call the office within 24 hours will result in a **$25.00 NO SHOW FEE**. This fee is not payable by your insurance company and will be your responsibility

MEDICAL RECORDS: A copy of your medical records can be provided upon receipt of a written authorization of release signed by the patient or guardian. A nominal fee will be charged to cover the costs of fulfilling each request in compliance with Illinois statutes.

RELEASE OF INFORMATION and AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I authorize Pro-Motion Physical Therapy to release to my insurance company or its representatives, information including the diagnosis and the records of any treatment or examination rendered to me that may be required to process my claim for benefits. I authorize and request that my insurance company pay directly to the above named practice the amount due in my pending claim for medical treatment or services, by reason of such treatment or services rendered to me. This assignment will remain in effect until revoked by me in writing.

I understand and agree that, regardless of my insurance policy, I am responsible for the entire balance on my account, for all professional services provided to the patient (or myself). I have read all the information contained in the Financial Policy. I certify that, to the best of my knowledge, this information completed on the Patient Information form is correct and true. I will notify this office in case of any changes to my health or any of the attached information.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read and choose not to) and understood the Notice.

Date: _____ Signature: _____

Patient Name (Print): _____

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Patient or Authorized Representative (if applicable) Signature