

# ADVANCED SPINE PHYSICAL THERAPY

## **SELF-PAY FINANCIAL POLICY**

Welcome to Advanced Spine Physical Therapy. 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 to read and sign prior to treatment. In order for our relationship to be mutually satisfying and beneficial, we encourage you to discuss with us promptly and openly any concerns about your treatment, services or fees. Any misunderstandings and lack of communication can only lead to dissatisfaction.

Our patients can expect:

- High degree of professional skill and ability
- Fees that are customary for our area

In return we expect:

- Cooperation in making and keeping appointments
- Your payment of fees (for which you are personally responsible) at the time of service
- Your assistance in keeping us informed of your current health insurance information

### **Method of payment**

1. We accept cash, check\* or credit card (Visa, MasterCard or Discover)

\*A fee of \$25.00 will be charged on all returned checks.

As agreed, payment of \$90.00 for the first visit which includes the initial evaluation and treatment, and \$75.00 per visit thereafter is required to be paid in full at each visit. If after the initial evaluation you would like to pay in advance for five (5) additional treatments, the cost for each visit will be \$60.00 for a total of \$300.00. This will be non-refundable in the event of cancellation or no-show of the appointments scheduled.

### **Minor Patients**

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.

### **Cancellations and Missed Appointments**

If needed, please cancel your appointment at least **24 hours** in advance. Appointments not canceled 24 hours prior to scheduled time will be charged a fee of \$50.00

### **Collections**

In the event a patient's account is delinquent or a patient fails to abide by these financial terms, the account will be handed over for collection and the responsible party will be liable for any collection fees, attorney fees and court costs.

### **Financial Agreement**

I have read and understood the above financial policy, and agree that services received cannot be submitted to my health insurance company towards my deductible or for reimbursement. My signature below denotes agreement between \_\_\_\_\_ and Advanced Spine Physical Therapy for Physical Therapy and Occupational Therapy services rendered.

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**PRINT NAME**

**SIGNATURE OF PATIENT OR GUARDIAN**

**DATE**