Physical Therapy & Wellness Center

Payment Policy

Thank you for choosing Apex Physical Therapy & Wellness Center. We are committed to providing you with quality and affordable health care. Please read this agreement, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request

1. **Insurance.** We participate in most all insurance plans. If you do not wish to use your insurance and/or are not insured by a plan we do business with, payment in full is expected at each visit at a discounted rate. See **cash for service** for explanation. If you are insured by a plan we do business with and wish to use your insurance, a copy of your insurance card is required and it must be up-to-date. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage or check with the front desk to receive a quote they have received from your insurance company regarding your policy. All patients must complete our patient information form before seeing our providers.

2. **Co-payments.** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Cash for service.** We at Apex are committed to fair and reasonable fees. Part of our fees and charges are calculated to pay for the office cost of submitting claims to insurance companies, the delay/lag in payment from these agencies, and the claim denial and/or non-recovery of charges. With these factors taken into consideration, we have calculated a discounted cash price option that we offer if paid in full that would not be submitted to your insurance or an option should you not have insurance. These arrangements must be made prior to your visit.

4. **Non-covered services.** Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you on an emergency basis.

8. **Missed appointments.** As a courtesy to our office as well as to those patients who are waiting to schedule, we ask that you please give us at least 24 hours' notice prior to cancelling or rescheduling an appointment. **If you do not call and notify our office that you cannot make your appointment, we will assess a $35 "no-show" fee to your account.** These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party **Date**

 "Why Every Practice Needs a Payment Policy." Ciletti MV. *Family Practice Management*. April 2004:17-20, http://www.aafp.org/fpm/20040400/17w Updated 12/14/23