

## Agapé Physical Therapy

~Please read the following information and sign when finished~

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### Financial Policy

I, the undersigned, certify that I (or my dependent) have insurance coverage with the named insurance on the patient registration form and assign directly to Agapé Physical Therapy all insurance benefits, if any, otherwise payable to me for services rendered.

**Co-payments are due at the beginning of service and not considered billable.** This is a contractual agreement between you and your insurance company. This includes Preferred Care, BlueChoice and many other private insurance plans.

If your contract carries a **co-insurance responsibility a \$15.00 payment will be due at each visit.** This amount will **not** cover the total amount due for each visit; this amount is taken to offset the final balance and will be credited toward your total responsibility. You will be billed for the remaining due once your insurance has processed your claims. In the event that you overpay we will reimburse you the difference once your insurance carrier has processed and paid all your claims.

We participate in a number of insurance plans to whom we will submit a claim on your behalf for covered services and bill you for any remaining balances. Balances are due within 30 days and are considered past due after that. These plans include BlueCross BlueShield plans, Medicare and some private insurance plans.

If your insurance carrier refuses to pay for services rendered, your deductible has not been met, or you classify as self-pay you will be required to pay Agapé Physical Therapy all applicable costs for services rendered. In the event of non-payment, your account will be assigned to collections and shall be liable for the charges paid for the collection agency.

**A \$15.00 fee will be charged to your account every time a “No-show” occurs,** this amount will be **due at your next visit in addition to your regular co-pay or co-insurance amount.** Any returned checks for insufficient funds will be charged a \$10.00 bank fee.

I hereby verify that I have read and understand the above financial policy. I authorize Agapé Physical Therapy to release all information necessary to secure the payment of benefits and to use this signature on all insurance submissions.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Print Name \_\_\_\_\_ Relation to patient: \_\_\_\_\_