

**HOUGHTON PHYSICAL THERAPY
FINANCIAL POLICY**

TO OUR VALUED PATIENTS:

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, **we need your assistance**, and your understanding of our payment policy.

Payment for services is due on each visit for charges incurred up through your last visit. We accept cash, checks, MasterCard, or Visa. We bill electronically, to expedite payment of claims.

Please read carefully:

1. Your insurance is a contract between you, your employer and your insurance co. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. "U.C.R." is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility.
4. **Medicare patients are responsible for the yearly deductible and if Medicare is the only insurance you are responsible for 20%.**

SIGNATURE: _____ **DATE:** _____

5. If this injury is work related, and a Workers Compensation claim has been initiated, you are given 10 visits with no claim number, if after the 10th visit, a claim number has not been received, or your case is denied by BWC, then you are responsible for each additional visit. **We require, on your initial visit, that you provide us with your medical insurance to insure payment of the account if your case is not allowed. If you already have a claim number, please provide us with the number on the registration form.** If you have an attorney, please provide this information on the registration form
6. For liability cases, where another party is responsible, you need to provide us with all the billing information. If you have an attorney, please provide this information on the registration form. It is this office's policy that a letter of protection, also known as a lien must be received from your attorney within the first 2 weeks of your treatment. Without this letter, you become responsible for the account in full.

Again, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. **We are here to help you!**

I have read the above policies and agree.

SIGNATURE: _____ **DATE:** _____

HOUGHTON PHYSICAL THERAPY

Medical History

Have you been treated here or by another physical therapist previously? Yes ____ No ____

If yes, where? _____ When? _____

Was it for the same condition? Yes ____ No ____ If not, please specify: _____

Date of onset of current episode of symptoms/injuries/illness: _____

Place of injury: Home ____ School ____ Work ____ Auto ____ Other _____

Parts of BODY being treated for this injury: _____

Responsibility Information

Who will be primarily responsible for the bill? _____

I will be paying my share of financial responsibility by: Cash ____ Check ____ Credit Card ____

PRIMARY Insurance Company: _____ Phone #: _____

Policy Holder's Name: _____
last first middle

DOB _____

Policy #: _____ Group#: _____

Address: _____
street city state zip

Policy Holder's Employer: _____

Employer's Address: _____
street city state zip

Position: _____ Phone: _____

Is there Secondary Insurance? Yes ____ No ____

Name of Secondary Insurance Company: _____

Policy #: _____ Group# _____

IS THIS A WORKER'S COMPENSATION CLAIM? Yes ____ No ____ Date of Injury: _____

Company: _____ Address: _____

Phone Number: _____ Claim #: _____ Contact Person: _____

IS THIS AN ACCIDENT CASE? Yes ___ No ___ VEHICLE ___ OTHER _____

Insurance Company to Bill: _____

Address: _____
street city state zip

Phone #: _____ Claim #: _____

Adjuster Name: _____

Is there an attorney involved in your case? Yes _____ No _____

Attorney's Name: _____ Phone: _____

Address: _____ city
state zip

I hereby authorize HOUGHTON PHYSICAL Therapy's, Inc. to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist(s) all payments for service rendered. I understand that I am responsible for all charges, even those not paid by my insurance. I understand that by signing I am giving my permission for treatment. I also authorize Houghton Physical Therapy, Inc. to contact the insurance commissioner on my behalf, to assist me in receiving my full insurance benefits, if deemed necessary.

SIGNATURE: _____ DATE: _____

Signature for Minor (under 18 years of age) _____

RECEPTIONIST INITIALS _____