# OrthoFlex Physical Therapy & Rehabilitation P.C.

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## OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment.

All patients must complete our information and insurance form before seeing the therapist.

Full payment is due at time of service.

We accept cash and checks.

We do not accept LIENS.

Regarding Insurance:

We accept assignment of insurance under most plans. We cannot bill your insurance unless you give us your insurance information and an original claim form is necessary. Your insurance policy is a contract between you and your insurance company. We are not part of that contract. Please be aware that some, and perhaps all of the services provided may be non-covered services not considered reasonable and necessary under the Medicare Program and/or other medical insurance. The balance due is your responsibility whether your insurance company pays or not.

Regarding insurance plans where we are a participating provider. All co insurance and deductibles are due at time of treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients:

Adult patients are responsible for full payment at the time of service.

Minor Patients:

The accompanying adult of minor and /or parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless payment by cash or check at time of service has been verified.

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Signature of Patient/Responsible Party Date