PROVIDER FINANCIAL POLICY

PLEASE INITIAL EACH LINE AFTER READING AND SIGN AT THE BOTTOM OF THE PAGE.

☐ A copy of your insurance card is requested upon your first visit. With the co-pay payment due at the time of service. For your convenience we accept debit and credit cards as well as checks with proper I.D. A $20.00 charge will be made for returned checks.

☐ As a courtesy to you, our office will file a claim to your primary and secondary insurance plans. Any balance remaining after insurance payment is due within 30 days of final payment by insurance company.

☐ Payment for equipment you are purchasing is due upon receipt. If you decide you do not want it you will have 30 days to return the item in its original packaging. Once the item has been used there will be no refund issued.

☐ If you are involved in an accident, we will be happy to provide you with care. In most cases we will file claims with a third-party liability insurance plan. If there is a chance that your injury may end up in litigation, we will look to you for payment. We will not carry the balance until the case is settled. You will need to speak with our financial counselor if you need to set up payment arrangements.

☐ I understand that it is my full responsibility to inform JET Physical Therapy of any changes that may occur regarding my insurance coverage for the services that I or the individual named below has received.

☐ I understand that if I do not have insurance coverage I will be responsible for the full amount of charges incurred and payment will be made at the time of my visit.

Worker's compensation patients only

☐ Patient receiving care for a worker's compensation injury will provide JET Physical Therapy with the claim information or verify that JET Physical Therapy has received claim information prior to receiving treatment.

I have read the above policy regarding my financial responsibility to JET Physical Therapy for providing rehabilitative services to me or the individual named below. **I AGREE TO PAY ANY AND ALL PHYSICAL THERAPY CHARGES THAT EXCEED, OR THAT ARE NOT COVERED BY MY INSURANCE PROVIDER.**

I have also read the HIPAA privacy rights and am aware of my rights and understand the document.

PATIENT SIGNATURE (OR PARENT IF PATIENT IS A MINOR) _____

PRINTED NAME _____ DATE _____

THANK YOU

FOR CHOOSING OUR TEAM FOR YOUR HEALTH CARE NEEDS.