



Welcome to Sierra Nevada Physical Therapy. It is my goal to provide you with personalized and professional care during your period of rehabilitation. If you have any questions or concerns regarding your physical therapy, please feel free to discuss them with me.

As a patient receiving medical care, you should be aware of the following payment guidelines:

**1. FOR PATIENTS WHO ARE PAYING CASH, CHECK, OR CREDIT CARD FOR PHYSICAL THERAPY SERVICES:** your payment is due at the time of service. Upon your request, I will, as a courtesy to you, bill your insurance company so you can be reimbursed.

**2. FOR PATIENTS WHO WOULD LIKE ME TO CHARGE THEIR INSURANCE COMPANY FOR PHYSICAL THERAPY SERVICES:** Insurance is billed electronically. Please contact your insurance company 7 to 10 days after your appointment to make sure they are able to process the insurance claim or preauthorization. Balances are the patient's responsibility. In order to process insurance claims, we must have the following: Insurance Card, Social Security Number, and Photo ID.

**Payment:** Your portion of the your physical therapy bill will be due when you are notified by me of the amount due. Insurance co-pays are due at the time of your physical therapy treatment. **A 2% finance fee** will be added to bills that are 30 days past due from your billing notification letter. **An additional 2% finance fee** will be added to bills that are 60 days past due. **Any balance 90 days or more past due is subject to collection proceedings.**

**3. Any credit balance that may occur will be refunded as soon as possible, as per your request. A \$25.00 fee will be charged for any returned checks.**

You are responsible for charges incurred during your rehabilitation. I understand that where appropriate, credit bureau reports may be obtained. I agree to pay all attorney fees and collection fees should collection proceedings become necessary. Insurance policies are contracts between the patient and the insurance company and in no way constitute obligation for financial remuneration for physical therapy services. By signing below, I authorize release of any information relating to my insurance claim. Payments are made directly to Sierra Nevada Physical Therapy. **I am responsible for all charges and balances due with in 30 days of my notification letter.** I understand and agree to the above policy.

X \_\_\_\_\_

Print name

X \_\_\_\_\_

Signature of patient

\_\_\_\_\_

Date