ALHAMBRA VALLEY
PHYSICAL THERAPY

Financial Agreement

This office will strive to bill your insurance in a timely and professional manner. We will check your benefits and eligibility with your insurance if requested by you. We will help with appeals and re-billings to obtain the highest benefits for you if possible. If you are experiencing a financial hardship, please feel free to speak with our office regarding payment arrangements. However, you do have the responsibilities listed below. Please read carefully and sign where indicated.

PRIVATE INSURANCE

I understand that this office bills my insurance as a courtesy to me. I understand that I am ultimately responsible for any outstanding or uncovered services.

I understand that confirming whether this office is contracted with my insurance or as a preferred provider is ultimately my responsibility.

I understand I will be billed for deductibles, copayments, and uncovered charges.

MEDICARE

Medicare cap for physical therapy and speech therapy services is $1940 per year (about 16-17 visits depending on your treatment procedures). We will advise you when you are about to approach the limit.

COPAYMENTS ARE DUE AT THE TIME OF YOUR VISIT.
OUR OFFICE REQUIRES A 24 HOUR ADVANCE NOTICE WHEN CANCELLING APPOINTMENTS. YOU WILL BE CHARGED A $50 FEE IF: YOU DO NOT CALL AND CANCEL WITHIN 24 HOURS OF YOUR SCHEDULED APPOINTMENT, YOU NO SHOW TO A SCHEDULED APPOINTMENT, OR WE CANCEL YOUR APPOINTMENT IF YOU SHOW UP MORE THAN 15 MINUTE LATE.

Signed:_____Print Name:_____Date:_____

WORKERS COMPENSATION

I understand that I will not be billed for any services if my injury is work related; however if my case is denied by the insurance carrier as not work related, or if this office's services are denied as not related to my work injury, then I will be responsible for all outstanding charges.

I understand that if I do not cancel a scheduled appointment within 24 hours, no show to a scheduled appointment, or am more than 15 minutes late and my scheduled appointment needs to be cancelled, that my worker's compensation adjustor will be notified after the second occurrence, and I will be referred to another facility after the third occurrence.

Signed:_____Print Name:_____Date:_____

MOTOR VEHICLE ACCIDENTS

I understand that I am responsible for all charges incurred at this office. I understand that this office will bill my insurance, and may agree to accept a third party liability case; however I will still be responsible for all charges when I receive my settlement.

Signed:_____Print Name:_____Date:_____

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to be paid directly to Alhambra Valley Physical Therapy; Joan Arieta, RPT, DPT.

Signed:_____Print Name:_____Date:_____