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 initial where indicated.

COPAYMENTS ARE DUE AT THE TIME OF YOUR VISIT.

_____ Initial

YOU WILL BE CHARGED A $50 FEE IF:

- **You do not call and cancel within 24 hours of your appointment.**
- **You no show to an appointment.**
- **You are more than 15 minutes late and we have to cancel your appointment.**

_____ Initial

PRIVATE INSURANCE

- I understand that estimated coverage information is provided as a courtesy to our patients and is not a guarantee of payment.
- 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 responsible for $100 for the evaluation and $50 dollars each visit, if my deductible has not been met.
- I understand I will be billed for remaining deductibles, copayments, and uncovered charges.

_____ Initial

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.

_____ Initial

MEDICARE

Medicare cap for physical therapy and speech therapy services is $2150 per year (about 16-18 visits depending on your treatment procedures). We will advise you when you are about to approach the limit.

_____ Initial

ASSIGNMENT OF BENEFITS

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

_____ Initial

PLEASE CHOOSE ONE. Reminder calls are automated, by either text or voicemail. Please check which option you would like, or you may opt out of receiving reminders by checking none:

o Home:_____ o Cell: _____ o Text: _____ o None

I have read, understood and agree to the policies listed above. I have been given the opportunity to ask questions, and can be provided copies if requested.

Signed:_____Print Name:_____Date:_____

Address:_____