Hands On
PHYSICAL THERAPY

Financial Responsibility

As a patient of Hands On Physical Therapy, it is your responsibility to know and recognize your insurance benefits. You are responsible for payment of deductibles and co-pays at each visit. Not all services/supplies are covered by insurance. In the event that your carrier does not cover a service, you will be responsible. Insurance can and will deny payment for services if they deem them medically unnecessary. In the event that this situation arises, it is your responsibility for payment of any denied charges.

In order to find out what your insurance covers, you can call the customer service number located on your insurance card. Any further questions may be answered by calling your employer's human resources department.

Our office will contact your insurance carrier for your benefits. This information is only an interpretation and is not a guarantee of payment or coverage.

Please make sure that your insurance covers this facility. Benefits and coverage change between insurance companies and may vary between policies under that same insurance.

Please be aware that our office does not file through third party payers for auto accidents.

Please inform the front office staff of any modifications or changes made by your insurance. These may include employment changes, plan cut-back or a new insurance card. It is ultimately your responsibility for supplying this information to us.

Any accounts that are not paid in full after three warning letters will be turned over to our collections agency. You are subject to all attorney and court fees once your account has been turned to collections. In order to attend therapy at our facility in the future, all fees and account balances must be paid in full.

Payment arrangements may be made with the front office staff in order to make your visits more affordable. These arrangements may include account balances, payments toward deductibles and/or co-pays. **Note that if partial payments are being made toward visits, payments will continue to be collected after services are finished until the account balance is paid in full.**

I understand the policy I have read. I know that I am responsible for any expenses incurred at this facility. I hereby give my authorization to release my medical information to my insurance company in order to process claims and to receive payment under my policy.

Patient Signature:_____ **Date:**_____

Parent/Guardian Signature:_____ **Date:**_____