Dominion Physical Therapy, LLC FINANCIAL POLICY

Thank you for choosing Dominion Physical Therapy, LLC (DPT, LLC) as your family rehabilitation provider. We are committed to giving you the best experience possible while recovering. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. **All patients must complete this information before seeing the provider**.

Regarding Insurance

We may accept assignment of insurance benefits. However, **we do require that all co-payments be made at time of service.** The balance is your responsibility whether or not your insurance pays or not. We cannot bill your insurance company unless you give us your current insurance information. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. You will be responsible for these balances. Should your insurance coverage change while you are still receiving care it is your responsibility to provide us with this new insurance information. We will not be able to submit claims without this information.

Initial_____

I understand that it is **my own responsibility to understand my insurance coverage** as it relates to the services I am about to receive. I understand that my insurance company has provided a toll-free phone number on my insurance card that I can call at any time to ask any questions regarding coverage, eligibility, exclusions, deductibles, co-pays, or any other inquiry I may have. I understand that DPT, LLC in no way has any power to dictate policy or procedure of my own insurance company.

Initial_____

I understand that **my own insurance company decides** what to reimburse DPT, LLC only after bills are submitted and reviewed. DPT, LLC has no authority or ability to decide what treatments will/will not be paid nor at what price. Only my insurance company knows this information once bills are submitted.

Initial_____

There will be a $50.00 returned check fee on all returned checks. Initial_____

I **hereby authorize Dominion Physical Therapy, LLC** to render medical services to myself (or child) and to release any information regarding my medical history, diagnosis, treatment of myself (or child, if applicable) to my insurance company regarding my claim for benefits. I authorize payment directly to Dominion Physical Therapy, LLC for the benefit otherwise payable to me under the terms of my insurance. Dominion Physical Therapy, LLC will file for insurance coverage; however, if the insurance company payments are not timely, it is my responsibility to pay Dominion Physical Therapy, LLC and pursue any recovery with the insurance carrier. I understand that I am financially responsible for all the charges arising for the treatment of the patient named here. If this contract is referred to an attorney or collection agency for collection, I agree to pay all attorney or collection fees in the amount of thirty percent (30%) of the total indebtedness and all court costs incurred by Dominion Physical Therapy, LLC. If the indebtedness is not paid in full within sixty days, I agree to pay a service charge of one and one-half (1 ½%) per month, eighteen percent (18%) annum.

_____
Printed Name

_____ _____
Signature Date

RETURN PAPERWORK TO FRONT DESK