ENCORE
PHYSICAL THERAPY

Financial Policy

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have and questions about our fees, financial policy or your financial responsibility.

We will request a photocopy of the front and back of your insurance identification card and driver's license. Please update your care with any additional information your insurance company provides which will facilitate the submissions claims on your behalf. It is your responsibility to inform us of any changes to your policy. We will bill your insurance company on your behalf as a courtesy.

Co-Payments: We must collect your carrier-designated co-pay at the time of service. We will bill you for coinsurance or other balances due after we have been paid by your insurance company or notified of their denial for payment.

Missed Appointments: Patients who do not show up for an appointment, and do not call to cancel have impacted other patient's ability to obtain timely medical care. Therefore, subject to the individual patient's insurance contract, we reserve the right to charge a $25.00 fee for missed appointments.

Insurance: We will gladly bill and accept payment from your health insurance plan. Your co-payment or deductible is due and payable at the time of service. We accept cash, checks, MasterCard and Visa. Any amounts not covered by your insurance carrier are your responsibility.

We find communication between our office and our patients help us to succeed in providing the best care. Please advise us if your insurance company has pre-certification and/or prior authorization requirements and/or policy restrictions and limitations.

I have read and understand the above. I hereby authorize Encore Physical Therapy to submit claims to my insurance carrier. I hereby authorize direct payment of benefits, otherwise payable to me, to be made payable to Encore Physical Therapy. I understand I will be responsible for payment of any amounts not covered by my insurance carrier, including, but not limited to, co-payments and deductibles.

Signature:_____ Date:_____