espt
orthopedics · fitness · women's health

Exercise Sport Physical Therapy

FINANCIAL & HIPAA

FINANCIAL POLICY

College Park Physical Therapy will bill your insurance carrier, solely as a courtesy to you. You are responsible for the entire bill for services rendered. Any balances, co-pays and/or deductibles are due prior to seeing the therapist. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. You also understand that you are responsible for any amount not covered by your insurance. In the event that your insurance company requests a refund of the payment made, you will be responsible for the entire charge amount.

If you do not have insurance, payment is expected when services are rendered. If payment in full is not possible at the time services are rendered, payment arrangements may be made in advance. You must notify the front desk, prior to your appointment, if you are unable to pay in full.

I understand and agree if I fail to make payments for which I am responsible, in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, interest and attorney fees.

Returned Check Fees: Any returned check from the bank for non-payment (insufficient funds) may result in the patient's account being assesses a $30.00 fee, per check returned, in addition to the balance owed. Multiple returned checks may result in you having to pay cash or credit card at the time of service and your check may be denied.

MEDICARE PATIENTS:

I authorize any holder of medical or other information about me to be released to the Social Security Administration, its intermediaries, carriers any information needed for this, or, a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignments below.

GUARANTEE OF ACCOUNT:

For, and in consideration of, services rendered to Patient Named, by **College Park Physical Therapy**. I hereby agree to pay the full bill for all charges which are not paid to **College Park Physical Therapy** by insurance carriers, Workers' Compensation, MVA, No-fault or any balance due for services not covered by insurance or excluded by a co-insurance clause.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

I permit **College Park Physical Therapy** to disclose all or part of the named patient's medical records to any person, corporation or agency when required for the collection of benefits or payment to **College Park Physical Therapy**.

CONSENT TO TELEPHONE CALLS FOR FINANCIAL COMMUNICATION

I agree that, in order for **College Park Physical Therapy** collection agents to service my account, or, to collect any amounts I may owe, I expressly agree and consent that **College Park Physical Therapy** and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or **College Park Physical Therapy** and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I HAVE READ AND UNDERSTAND THE POTENTIAL RESPONSIBILITY AND FULL PAYMENT OF MY ACCOUNT.

Facility Name: **College Park Physical Therapy**

Patient PRINTED Name	Parent/Guardian PRINTED Name (if Minor Patient)
Patient SIGNATURE Name (Parent/Guardian Signature if Minor)	Date