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MITCHELL PHYSICAL THERAPY

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Financial And Privacy Policy

Mitchell Physical Therapy Inc. is committed to providing you with the best possible medical care. Please carefully read the following, and complete the enclosed forms. If you have any questions regarding our policies, please do not hesitate to discuss them with our office manager.

PAYMENT FOR SERVICES is due at the time services are rendered or upon receipt of a patient billing statement. In order to expedite this payment we accept cash, personal checks or VISA/MASTERCARD.

Insurance:

1. For your convenience, we will bill primary and secondary insurance. We are not able to bill a third insurance. You are responsible for the payment of you balance in a timely manner regardless of discrepancies and /or disputes with your insurance carrier.
2. **Co-Pays:** All co-pays, if required by your plan, are due at the time of service for each visit. There will be a $10.00 charge for billing any co-pay that is not paid at the time of service.
3. **Deductible Policy:** If you have an annual deductible over $500 that has not been met, we will collect $50 at each visit to be applied to your account until your deductible has been met.
4. If your insurance changes during treatment, it is your responsibility to give us your new insurance information **PRIOR** to your next appointment. If the information is not updated, you will be charged the point of service charge for the appointment.
5. The parent or guardian who registers a minor child is ultimately responsible for the payment of the charges incurred at this facility regardless of circumstances involving divorce, custody, etc.
6. **Please be advised:** Patients are required to pay balances within 30 days of receiving a statement. A $10.00 rebill fee per statement will be applied for all balances over 30 days.
7. **Payment Plans:** If you believe you will need to set up a payment plan, arrangements will need to be made with our billing department and are subject to approval.
8. *I understand if I have an unpaid balance to **Mitchell Physical Therapy Inc**. and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of any fees from the collection agency, including all costs and expenses incurred collecting my account, and possibly including reasonable attorney's fees if so incurred during collection efforts.*
9. *In order for Mitchell Physical Therapy Inc. or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Mitchell Physical Therapy Inc. and the designated external collection agency are authorized to (i) contact me by telephone at the telephone number(s) I am providing, including wireless telephone numbers, which could result in charges to me, (ii) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (iii) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable.*

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We will make every effort to verify that we can treat you. <u>This is however, no guarantee of benefit.</u> Any questions regarding your policy deductible or coinsurance please contact your insurance company.

- **Motor vehicle Accident (MVA):** Mitchell Physical Therapy, Inc. will submit the appropriate claim to your carrier. If your claim is denied, you will be responsible for the entire balance. If your Personal Injury Protection (PIP) coverage runs out, or if your claim is in dispute, you will be responsible for the remaining balance. We will not carry the balance until your settlement, as we are not a party to your claim.
- **Worker's Compensation (W/C):** Mitchell Physical Therapy, Inc. will submit the appropriate claim to your carrier. If your claim is denied, or if it is in dispute, we will bill your regular medical insurance carrier pursuant to ORS 656.131. If your claim is denied and you do not have medical coverage, or if your insurance is not accepted by Mitchell Physical Therapy, Inc., you will be responsible for the entire balance. **Your bill is then due and payable upon receipt of the bill.**

<u>No Show Fee:</u> All no shows (as well as same day/short notice cancellations) are subject to a fee of $50. We require at least a 24-hour notice if you are unable to keep your appointment.

<u>Returned Check:</u> There is a $50 fee for all returned checks.

I have read and understand this financial policy for Mitchell Physical Therapy. I accept the terms listed above.

☐ I have received, or been offered, the HIPPA Notice of Privacy Practices. (Copies are also posted in office)

_____

Patient/Guardian Name (Printed)

_____ _____

Patient/Guardian Signature **Date**

Updated 04/15/2020