

Health in Motion Physical Therapy, Inc.

Billing and Payment Policy

As validated by my signature on this form, I understand that as the responsible party:

- ___ 1. I am ultimately responsible for payment in full of all charges (including all past due and current balances and interest on balances over 30 days), regardless of insurance coverage.
- ___ 2. I understand that HIMPT will bill my insurance company on my behalf. I understand that I am responsible for knowing the policy and provisions of my insurance plan, **and I understand that there is no guarantee of payment.**
- ___ 3. I agree to pay my co-payment, if insurance is directly billed, or 30% per visit.
- ___ 4. I agree to pay unpaid balances exceeding thirty (30) days, even when insurance claims are pending, unless other arrangements are made with HIMPT. After thirty (30) days, accounts will be subject to a monthly finance charge of 1.5% on outstanding balances until paid in full.
- ___ 5. VISA, MASTERCARD, CASH AND/ OR CHECK can be used for payment on my account. A \$ 30.00 charge will be applied to all returned checks.
- ___ 6. I agree that in the event legal action should become necessary to collect an unpaid balance due for physical therapy services rendered, I will be responsible for all finance charges, collection fees, and court costs in addition to the outstanding balance.
- ___ 7. I understand that a 24 hour notice is *REQUIRED* on cancellation of appointments. I understand that I am responsible for *Cancellation-Late show-No show* fees of \$25.00. I understand that if I am late more than 15 minutes, I will need to reschedule my appointment and I will be charged a \$25.00 fee. I understand that with 3 *No Shows*, I will be discharged. I understand that insurance carriers will not be billed for these charges and that these charges are payable by me. If *UNPAID* these charges/fees *will* be sent to collections and all fees and costs of the collection will apply.

A copy of this agreement is available to me upon request.

Patient Name: _____ Date: _____

Signature of responsible party: _____

For Workers Compensation, Auto and Veterans Administration Patients

- ___ I understand that I am required to attain prior authorization and submit information to HIMPT.
- ___ I will be billed and held responsible for any charges not approved as a related incident by my Workers' Compensation, Auto or VA carrier.
- ___ If my Workers' Compensation, Auto or VA carrier requires payment of a co-pay, I will be responsible for that payment on a per visit basis.

For Medicare Patients

- ___ I understand HIMPT is required by law to bill Medicare directly for my service. I am responsible for the co-payment/co-insurance and yearly deductible portion of my physical therapy charges and any non-covered services that I choose to obtain.

For Medicaid Patients

- ___ I understand that HIMPT is required by law to bill Medicaid directly for my service. I am responsible for the co-payment portion of my physical therapy charges