

# Powhatan Physical Therapy Corporation

1555 Standing Ridge Dr., • Suite C-1 • Powhatan, VA 23139  
Office: 804-794-9023 • Fax: 804-794-9373

## **PAYMENT POLICY & AGREEMENT ASSIGNMENT OF INSURANCE BENEFITS**

THANK YOU FOR CHOOSING POWHATAN PHYSICAL THERAPY CORPORATION FOR YOUR SPECIALTY CARE.

We believe that the patient-therapist relationship is based upon mutual trust and understanding, and that it is important for you to have a clear understanding of your rights and responsibilities. We ask that you carefully review the following information, and if you have any questions or concerns, please ask us.

### **RELEASE OF PRIVATE MEDICAL INFORMATION**

By signing this agreement, you authorized POWHATAN PHYSICAL THERAPY CORPORATION to furnish any insurance carrier(s) or other third party payors or their agents, attorneys, or legal representatives all pertinent medical information which said parties may request concerning your illness or injury, which they deem necessary to determine coverage or which may be required to render payment. You also agree to assign POWHATAN PHYSICAL THERAPY CORPORATION any and all health care benefits to which you are entitled under any policy of insurance and authorized, to the extent permitted by law, payment of those benefits directly to POWHATAN PHYSICAL THERAPY CORPORATION.

### **PAYMENT POLICIES**

By signing this agreement, you agree to pay for the following:

- Any co-payments that are required by your insurance carrier
- Any co-insurance and/or deductibles that are required by your insurance carrier
- Any charges for service that you agree to have performed, that are not covered by your insurance plan.

### **INSURANCE CLAIMS**

POWHATAN PHYSICAL THERAPY CORPORATION will submit your claims to your insurance carrier(s) for payment. If we do not receive payment from your insurance carrier(s) within sixty (60) days of submitting your claim, we will send you a balance due statement. Upon receipt of this statement, we encourage you to contact your insurance carrier if you believe they should pay for the services, or call us to make payment arrangements for yourself.

### **INSURANCE REQUIRED PRIOR APPROVAL OR A REFERRAL**

If your insurance carrier required prior approval or a referral, it is your responsibility to obtain the approval or referral, prior to your visit with POWHATAN PHYSICAL THERAPY CORPORATION. If you express a desire to be examined without having the required approval or referral, by signing this agreement, you agree to be responsible for payment in the event that your insurance carrier denies payment for the services you received.

### **PATIENTS WITHOUT INSURANCE**

Patients without insurance coverage are expected to make payment arrangements with one of our Financial Counselors prior to being seen by a therapist.

### **PHOTOCOPYING IDENTIFICATION**

By signing this agreement, you authorize POWHATAN PHYSICAL THERAPY CORPORATION to photocopy your identification cards, including, but not limited to your insurance card and driver's license.

### **UNPAID BALANCES**

Any unpaid balances remaining on your POWHATAN PHYSICAL THERAPY CORPORATION account more than 45 days after your insurance carrier has paid, may incur a collection charge and be transferred for collection action. An additional charge of up to 28% of the unpaid balance due may be charged to cover legal costs incurred in collection. Additionally, unpaid balances may incur finance charges at the rate of 1.5% per month.

### **FINANCIAL DIFFICULTIES**

For patients experiencing financial difficulties, we will gladly establish mutually agreed upon payment arrangements. If payments are made as agreed, no additional fees or interest will be assessed to the patient's account. If the agreed upon payment arrangements are not met, the full balance is due within 45 days. An additional charge of up to 28% of the unpaid balance due may be charged to cover legal costs incurred in collection. Additionally, unpaid balances may incur finance charges at the rate of 1.5% per month.

### **RETURNED CHECKS**

POWHATAN PHYSICAL THERAPY CORPORATION charges a \$35.00 fee for any returned check.

I have read and understand this Agreement. I agree to all the terms of this Agreement. I understand that POWHATAN PHYSICAL THERAPY CORPORATION will provide medical services to me in consideration of and reliance upon this Agreement. If the patient is a minor, an adult guarantor will be required before POWHATAN PHYSICAL THERAPY CORPORATION provides services.

\_\_\_\_\_  
Print the Patient or Guarantor's Name

\_\_\_\_\_  
Patient or Guarantor's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Minor Patient's Name

\_\_\_\_\_  
Relationship to Guarantor

\_\_\_\_\_  
Witness to Signature

\_\_\_\_\_  
Date