BIG SKY Physical Therapy

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Financial Policy

It is the policy of Big Sky Physical Therapy, PLLC to have a financial policy that clearly outlines patient and practice financial responsibilities. We are committed to providing our patients with the best possible medical care and minimizing administrative cost. This Financial Policy has been established with these objectives in mind, and to avoid any misunderstanding or disagreement concerning payment for professional services.

1. Our office participates with numerous insurance companies and managed health care programs. For patients that are members of one of these plans, our business office will submit a claim for services rendered. The patient must complete all necessary insurance information, including special forms, before leaving the office.
2. If a patient has insurance that we do not participate in, our office is happy to file a claim upon request; however, payment in full is expected at the time of service.
3. It is the patient's responsibility to pay any deductible, co-insurance, co-payment, or any portion of the charges as specified by the plan at the time of visit. Any medical services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of visit.
4. Payment for professional services can be made with cash, check, or personal credit card such as Visa, MasterCard or Discovery.
5. If a patient feels that he or she may require financial assistance, patient or responsible party must notify the practice staff before you see the therapist for referral to the appropriate individual. Patients that do not have insurance are expected to pay for services at time of service unless prior arrangements have been made with Big Sky Physical Therapy, PLLC.
6. The patient understands that in the event any unpaid balance is placed for collections with any third party collection agency, a fee of 50% of the unpaid balance will be added to the total amount due. This amount shall be in addition to any other costs incurred directly or indirectly to collect amounts owed under this agreement such as court costs, attorney fees, late fees, and any other fees so stated elsewhere. The authorized fee of 50% and the additional costs and charges listed above represent the actual costs incurred by Big Sky Physical Therapy to collect amounts owed under this agreement and a corresponding decrease in expected revenue resulting from this signer's failure to pay as specified in this agreement.
7. The patient understands interest of 1% per month may be added to outstanding balances.
8. It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice before the visit. Visit may be rescheduled, or the patient may be financially responsible due to lack of referral.
9. It is the patient's responsibility to provide us with the current insurance information and to bring their insurance card to each visit.
10. Our staff is happy to help with insurance questions relating to how a claim was filed or regarding any additional information the carrier might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company's member services department (contact phone number is on the insurance card).
11. The adult accompanying a minor (18 years old and younger) and the parents or guardians of the minor are responsible for payment at the time of service. For unaccompanied minors, payment by credit card, cash or check at time of service needs to be verified.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the business office. We are here to help you. Please sign that you have read and agree to this Financial Policy.

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Signature of Patient or Personal Representative Date

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Printed Name of Patient or Personal Representative Relationship to the Patient