Universal Progressive Therapy

PLEASE READ THOROUGHLY AND SIGN THIS SHEET

1. We will collect your deductible, co-pay, uncovered services or the percent you are responsible for at the time of your visit. Please be prepared to pay at the time of check-in, before you are seen by the therapist. I**t is the patient's responsibility to know the terms of their insurance plan.**
2. You must bring your insurance card and photo I.D. with you and any authorization information you may have. Without these, we will be unable to see you.
3. We will file your insurance if we are providers for your plan.
4. If your insurance denies payment on your account you will be asked to pay by check, cash or charge. If you do not pay in a timely fashion, you will be responsible for any and all charges not paid by your insurance company in accordance with the laws.
5. HMO or PPO PATIENTS REQUIRING A REFERRAL: You are responsible for making sure your visits with our office are authorized by your primary care physician (PCP). **This authorization must be obtained *before* your scheduled visit.** It is the patient's responsibility to make sure we have received authorization.
6. SELF-PAY PATIENTS: This category includes patients with no insurance and the patients who have an insurance plan with which we do not participate. Payment for services is required prior to services being rendered. We accept Visa, MasterCard, Discover and American Express, checks, cash and money orders. We will provide you with a receipt.
7. Should you need to **cancel or change your office visit appointment**, you will be subject to a **$50.00 charge** if you do not do so with **24 hours business day advanced notice**.
8. By signing below, I agree that I am financially responsible for any charges incurred for missed appointments in which I did not give the required advanced notice.

If you have any questions regarding this financial policy, please ask or call BEFORE you are seen by the therapist.

Patient or Guardian _ Date

Print Name