AGNELLO SPINE & SPORTS PHYSICAL THERAPY CONSENT/FINANCIAL POLICY

Consent To Treatment: I authorize physical therapy treatment including but not limited to various therapeutic procedures and modalities per the therapist's professional judgment.

Regarding Insurance

We bill all insurance companies, however, if you have a question about how a claim was processed, you should contact your insurance company for answers. Your policy is a contract between **you** and **your insurance company**. Therefore, your balance is your responsibility, whether your insurance company pays a claim or not.

Non-covered services/items that are not covered by any insurance policies are to be paid for at the time of service.

Co-Payments

All HMO, POS and PPO insurance plans require payment at the time of service, or on a pre-arranged payment plan. If you do not pay your co-pay at the time of service, or according to the pre-arranged payment plan, you may be assessed a fee of $5.00.

Returned Check Fee

Any cost charged to us by our bank will be passed on to the responsible party. For example, our bank charges a fee of $25.00 for an NSF check. This $25.00 would be passed on to the responsible patient.

Divorced Parents

The adult accompanying the minor patient must pay at the time of service regardless of who the responsible party is. We cannot become involved in mediating financial arrangements between parents. Our computer system produces one statement for the listed responsible party. Please do not ask for us to send two statements for different percentages to different addresses.

Unaccompanied Minors

Unaccompanied minors should be provided with payment for their visits.

No Insurance Coverage

Patients with no insurance coverage are expected to pay at the time of service.

No-Show Appointment

If you do not contact our office to cancel a scheduled appointment with 24 hours notice, you will be billed a $25.00 "No Show" fee.

Payments

Payments can be made in cash, check or credit card. We accept Master Card, Visa and Discover only. A $10.00 fee will be applied each month for balances not paid in full. We want to be able to provide quality care; therefore we need you to make payments on your account balances.

I have read and understand that I am financially responsible for any balance, including balances remaining after insurance processing. I agree to make payments at the time of service according to the above criteria.

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Patient's Signature Date