MONTCLAIR PHYSICAL THERAPY INC.

ACTIVE METHOD PHYSICAL THERAPY

GET AMPT · BE STRONG

FINANCIAL POLICY

Thank you for choosing Montclair Physical Therapy for your rehabilitation needs. We appreciate that you have entrusted us and we are committed to providing you with the best care possible. Please carefully read through the following financial information.

***UPDATES**: Please inform MPT anytime there is any change to your address, telephone or other contact information. If you are issued a new insurance card please bring it with you. If your insurance changes or discontinues mid-treatment, please notify us immediately so there is no delay in billing.*

***MEDICAL INSURANCE COVERAGE**: Montclair Physical Therapy participates in most health plans, but not all. At the time of your initial visit we will attempt to verify your current insurance coverage. It is ultimately your responsibility to know your physical therapy benefits and all coverage is based on insurance coverage at the time of service. Rates are subject to change depending on your insurance policy.*

***CO-PAYMENTS AND DEDUCTIBLES**: As part of our contractual agreement with your insurance company we must collect these fees directly from you. Often your annual deductible must be met before insurance will pay for physical therapy benefits. Co-payments/Deductible will be collected at time of service.*

NOTE: Verification of Physical Therapy benefits is NOT a guarantee of payment.

***AUTOMOBILE MEDICAL INSURANCE**: We will bill your automobile insurance company for your treatment only when you have auto med-pay coverage with your policy. If you do not have auto med-pay, payment is due at the time of your service. We will provide you with documentation in order to facilitate reimbursement upon settlement of your case.*

***WORKERS COMPENSATION:** We will bill your workers compensation carrier for your charges. In the event of claim denial or fraud, you will become financially responsible for all treatment charges.*

***CASH CUSTOMER**: Please pay the balance in full at the time of service or upon receipt of invoice.*

***CANCELLATION POLICY**: We require **24-HOUR notice for cancellation** of a scheduled appointment. Failure to arrive **within 10 minutes** of your appointment time may result in the cancellation of your session. If there are more than **three no shows or late cancellations we will refer you back to your referring Physician**.*

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical and, if applicable, government benefits to Montclair Physical Therapy. I assign all payments for physical therapy services to Montclair Physical Therapy. I agree that I am responsible for payment of my physical therapy invoices, whether or not my insurance company is paying them. I agree to pay for attorney's fees, legal fees, court costs, and any costs incurred in the collection of delinquent accounts. I agree to pay charges for appointments not cancelled 24 hours in advance. Payment is due upon receipt of invoice. A 12% per annum charge will be added to any invoice that has been left unpaid past sixty days. Failure to maintain these arrangements may result in the placement of your account with an agency for collection.

Please sign and date this form to indicate that you understand and agree to all of the terms of the payment policy described above. Please let us know if you have any questions or concerns.

According to your insurance, you have a $_____ co-payment per visit.
Your annual deductible is $_____. You have a remaining deductible of $_____.
Your coinsurance is _____.

*Signature of Responsible Party*_____ *Date* _____

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