Payment Policy and Financial Agreement

Thank you for choosing Dee PT for your Physical Therapy needs. This financial agreement describes both patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have and sign in the space provided.

I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection agency. If it becomes necessary to send my account to a collection service, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonably attorneys' fees, we incur in such collection efforts. We are proud to say however, that only about 1% of our accounts are referred to collections.

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Parent/Guardian Signature	Printed Name	Date

Insurance

Your insurance coverage is a contract between you and the insurance company and we are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. It is also your responsibility to know your insurance benefits including referrals, pre-certifications and required authorizations. As a courtesy we will submit your claims to your primary and secondary insurance companies however we do expect payment for all services within 60 days. It may become necessary for you to pay your account in full if your insurance fails to do so within 60 days. If we are given incorrect or incomplete insurance information you will be billed and payment will be expected within 30 days, unless the issue is resolved.

Patient Responsibility & Payment

Payment of copays and deductibles will be due at time of service. Our failure to collect these amounts may be a violation of our contract with your insurance company. You are ultimately responsible if your insurance denies a claim for any reason. If you do not have insurance, payment in full will be due at time of service. The amount of your bill is expected to be paid in full within 30 days of the date on the statement, unless payment arrangements have been made with the Billing and Accounts Manager, or Billing Coordinator. Anything over 30 days is considered past due.

Payment Options

We understand that financial circumstances vary from patient to patient. If you are unable to pay your due balance in full you must call the office at 802-865-0010 to make payment arrangements. In order to stay in good standing a ***reasonable*** agreement must be established with the office.

Non-Payment

Failure to pay will result in your account being referred to a collection agency, which will affect your credit. NSF checks will result in a $25.00 returned check fee.

Attendance Policy, Consent to Treat, & HIPAA

Dee Physical Therapy strives to provide each patient with the highest quality care while accommodating patient schedules. We reserve time slots for each patient in order to minimize waiting time and assure continuity of care. Your consistent attendance of the planned treatment regimen is paramount to your full recovery!

- Last minute cancellation and patient no shows decrease our ability to accommodate the scheduling of other patients in need, so if you are unable to keep a scheduled appointment, ***we request 24 hours advance notice***.
- If you are going to be late for an appointment, please let us know as soon as you can. We will do our best to accommodate you; however there may be times we will need to reschedule.
- We are required to document all cancellations and missed visits in your medical record and report it to your physician and insurance company/third party payer. If you accumulate three cancelled or missed visits, your therapist may refer you back to your physician before scheduling another appointment.

Consent to Treat

I give permission for Dee Physical Therapy, LLC to provide the medical treatment appropriate and necessary for the rehabilitation of _____'s current physical condition.

Privacy

Dee Physical Therapy, LLC understands that you have read and are aware of the current rules and regulations regarding Patient Rights and Responsibilities. If you are unaware of these policies, please ask us for a copy. Any changes to the HIPAA Privacy Act, effective April 14, 2003, or patient rights will be posted in our office.

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:
Name:_____Relationship: _____
Name:_____Relationship:_____
I authorize disclosure of my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all related conditions).

I agree to and understand the above policies:

_____ _____
Patient/Guardian/Guarantor of Payment Signature Date

_____ _____
Facility Representative/Witness Date