# Financial Policy

***As a courtesy and convenience to you, Cascade Physical Therapy will bill your insurance on your behalf.***

**Payment options if you have insurance:** Providing correct and current insurance information is the responsibility of the patient. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. In order to meet the requirements of your contract, co-pays and sizeable deductibles must be paid at the time of service. If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower payment or no payment from your insurance company. Services cannot be provided on the assumption that the charges will be paid by the insurance company, therefore, the patient is responsible for the bill regardless of insurance coverage. If your insurance carrier changes, it is your responsibility to notify us immediately.

**Payment options if you do not have insurance or insurance funds are exhausted:** Patients without insurance coverage are requested to pay their charges at the time service is provided. We accept cash, checks or Visa/MasterCard.

**Workers Compensation:** We require written approval/authorization from your physician and your employer/workers compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full. If you have current medical insurance, we will bill your account balance at the time of denial. You will be responsible for any co-pay or deductible amounts assigned by your medical insurance.

**Personal Injury:** If you are being treated as part of a personal injury claim, we require a written referral from your physician at or prior to your first visit. We will also need your auto insurance carrier information, including the name of your adjustor, your claim number and your date of injury. If you are being treated as part of a personal injury lawsuit, we require you and your attorney to sign an agreement to protect payment of our bill from the proceeds of any settlement or judgment you may receive. In addition, we require that you allow us to bill any medical insurance you may have. In the absence of insurance, other financial arrangements may be discussed.

**Legal Representation**: In the event that you retain the services of an attorney, or change representation during or after the completion of your treatment, it is your responsibility to notify our office immediately.

**Accounts:** If you have a balance on your account, we will send you a monthly statement. It will show charges to your account, any payments or credits applied and any rebilling fees. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued and is past due if not paid by the due date. We have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service. If your account becomes past due, we will take the necessary steps to collect the debt including turning your account to a collection agency if necessary. A $10 rebilling fee will be applied each month to accounts not paid within 60 days of the first statement. If we refer your account to a collection agency, you agree to pay all of the collection costs including but not limited to, attorney fees, court costs and collections fees up to 50% of your account balance.

**Returned Checks:** Any checks returned by your bank will incur a $35.00 charge.

*This is an agreement between Cascade Physical Therapy as creditor, and the Patient/Debtor named on this form. In this form the words "you", "your" and "your" mean the Patient/Debtor. The word "account" means the account has been established in your name to which charges are made and payments credited. The words "we", "us" and "our" refer to Cascade Physical Therapy.*

*By executing this agreement, you are assuming full responsibility for payment for all services that are received.*

_____ _____

Patient Signature or Guardian if Patient is a Minor Date

Rev. 2/12