



Financial Policy

Carlson Therapy Network

As the patient, it is in your best interest to know and understand your insurance plan benefit. It is important that you know your responsibility for any deductibles, co-insurance or co-pay amounts prior to any visit. Regardless of your individual insurance coverage or type, as the person seeking medical treatment you are ultimately responsible for all charges. You are required to provide all information necessary so we can process your claims in a timely and efficient manner. If your insurance coverage changes during the course of your treatment, you must notify us immediately of that change and provide all information necessary.

Please know that we are here to help you if you have any questions!

MEDICARE-Medicare allows \$1840 for Physical and Speech therapy per calendar year. This payment amount may also subject to your Part B annual deductible. Please let us know if you have had therapy already this calendar year.

IN-NETWORK INSURANCE- Accurate and complete information is required at your first visit. If you have a copay, you are required to make the payment *at the time of service*. WE DO NOT BILL FOR COPAYS. If your policy requires a deductible or co-insurance, we will estimate your patient portion. If you have a balance due, you will be billed accordingly. In the event of an overpayment, you will be refunded once all claims have been paid. We know copays and co-insurance have continued to rise. Please understand we cannot reduce or waive your copay or co-insurance. If you have a financial hardship or difficulty with your payments, please speak with the clinic manager for your options.

IF YOUR INSURANCE CHANGES DURING YOUR COURSE OF TREATMENT- If your insurance changes during the course of treatment, you must provide this information prior to being seen at your next appointment. Many insurance companies require authorization that will not be backdated for *any* reason. If there is a time lapse between the effective date of your new policy and informing the clinic of your new insurance you will be responsible for any claims that are denied for any reason including lack of referral and/or authorization.

OUT OF NETWORK INSURANCE- If we do not participate with your insurance company, you will be responsible for payment in full at the time of service. We will fill out and mail your claims for you, but we will not follow up on or re-bill unpaid claims.

NO INSURANCE -If you are not insured, payment will be expected in full at the time of service. Please speak with the front desk for fees or to have any questions answered.

WORKERS COMPENSATION CLAIMS- It is the responsibility of the patient to give all information required for processing/obtaining authorizations and claim payment. This information shall include (but may not be limited to) your employer, date of injury, SSN, name of adjuster or case worker, case/claim number, contact phone number and insurance company address. Prior authorization must be obtained by the patient prior to being evaluated. In the event the claim is denied, you will be responsible for payment of any rendered service in full.

MEDICAID- There is no physical therapy coverage for patients over the age of 21 under any Medicaid plan. If you are under 21, we will process your claim according to contract guidelines. You are responsible for any co-pay you may have at the time of service.

****The Financial Policy continues on the back side of this page.**

MVA- NO MEDPAY COVERAGE- If you have been involved in a motor vehicle accident and do not have medical coverage on your automobile policy, we will require a letter from your automobile policy that states you do not have medical coverage. This letter is required to prevent delay in payment from your health insurance carrier.

MVA- MEDPAY COVERAGE-If you are being treated as the result of a motor vehicle accident, we are required to go through any medical coverage you may have on YOUR automobile policy (regardless of who was at fault) before going through your health insurance. You will be required to provide this office with the date of injury, your SSN, name of adjuster or case worker, case/claim number, contact phone number and insurance company address, and amount of medical coverage on your policy. You will need to track how much of your benefit has been used, as the turn around time for exhaustion letters generally leaves a balance that must be paid either by you or your health insurance carrier.

MINOR PATIENTS- The adult consenting treatment for the minor patient will be held financially responsible for services rendered.

DIVORCE- In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. The parent authorizing treatment for a child will be responsible for charges incurred. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

MISSED APPOINTMENT FEE- This office requires 24 hours notice if you cannot keep your scheduled appointment. If you miss your appointment or fail to give sufficient notice, you will be charged \$25.00 for that missed appointment. This payment is expected before any further treatment will be rendered and will be applied to the missed appointment only. If you miss three appointments through the course of your treatment, we reserve the right to cancel future appointments. If this payment is not received, we may refer this amount for collection.

PAST DUE ACCOUNTS- If your account becomes past due, we will take necessary steps to collect this debt. Your account will be referred to our collection agency. You will be charged for this service in addition to your current account balance. If payment is not received, your credit report will be blemished. If we have to refer collection of the balance to a lawyer, you agree to pay all of the lawyer's fees which we incur plus all court costs.

TRANSFERRING OF RECORDS- If, for any reason, you would like a copy of your entire record, you must request in writing, and pay a copying fee of \$.45 per page plus cost of postage. For your protection, please have proper ID with you if picking your records up in the office.

RETURNED CHECK FEE- There is a \$20.00 fee for any check returned by the bank.

I have read and understand the financial policy and I agree to adhere to its terms. Altering this form in any way will not change the policy as outlined above by Carlson Therapy Network.

Patient Name (Print)

Date

Signature of Responsible Party

Relationship (if not patient)