

**Premiere Rehab, LLC
Financial Policy**

Thank you for choosing us as your physical therapy provider. We are committed to your treatment being successful, and to working well with referring physician. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign.

All Patients must complete the patient information form before seeing the Therapist.

INSURANCE BENEFITS: We will verify insurance coverage, therapy benefits, deductible and co-insurance with your insurance company. **Verification of your insurance is not a guarantee of benefits.** Upon confirmation of your benefits, you will be responsible for any remaining deductible, co-pay, and any non covered services at the time of service unless other arrangements have been made. We will file your insurance for you; however, payment (either by your insurance carrier or your personal payment) is required every 30 days until your account is paid in full.

UCR-USUAL & CUSTOMARY RATES: Our practice is committed to providing the best treatment possible for our patients and we charge what is usual & customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual & customary rates, unless we have a current contract with your insurance carrier. You are also responsible for full payment of each visit regardless of any insurance company's arbitrary determination of what is not medically necessary and reasonable.

MEDICARE: We participate with Medicare and we file all supplemental policies. **By Federal Law all patients with Medicare must see their referring physician every 30 days, and receive a new prescription verifying the need for therapy before treatment can be rendered.** Medicare patients are required by Federal Law to pay 20% of the amount allowed by Medicare, which is due at the time of service. The annual deductible is due at the time of service, if not already satisfied with another medical provider.

COLLECTION CHARGES: The patient will be responsible for any collection charges incurred by us in pursuing payments from patients with delinquent accounts. (Currently 35% of balance)

MINOR PATIENTS: The adult accompanying the minor and the parents/guardians are responsible for payment. For unaccompanied minors, treatment will not be provided unless our charges have been pre-authorized to Visa/MasterCard or payment by cash or check at the time of service being verified.

MISSED APPOINTMENT: Unless canceled at least (1) hour in advance, our policy is to charge you for the missed appointment at the rate of a normal office visit/or (\$20). Please help us serve you better by keeping your scheduled appointments.

Thank you for understanding our FINANCIAL POLICY. Please let us know if you have any QUESTIONS OR CONCERNS. I have read the financial policy. I understand and agree to the information given in this financial policy.

SIGN:

Date:

(Signature of patient or responsible party)

I hereby authorize Premiere Rehab, LLC to bill my credit card account for any unpaid balance as stated above.

ACCT# _____ TYPE _____ EXP. DATE _____

POLICYHOLDER'S NAME _____ SIGNATURE _____