



FINANCIAL POLICIES AGREEMENT

Thank you for trusting Comber Physical Therapy and Fusion Chiropractic, LLC (Comber Physical Therapy) with your treatment needs. We are committed to providing you with the best patient care possible. Please carefully read through the following information, and do not hesitate to ask if you have any questions.

INSURANCE: Comber Physical Therapy is contracted with the majority of the regional health plan networks so that our patients may benefit from in-network coverage. If we participate with a patient's insurance company, the contracted adjustment will be applied to the claims, thus reducing the cost of the treatment. **While we attempt to verify insurance coverage, including effective dates, deductibles, co-payments, and co-insurance, verification of benefits is not a guarantee of coverage or payment, and the patient is fully responsible for any fees not covered by the insurance company for professional services rendered on each date of service.** Coverage and reimbursement rates may be affected by any changes made to the insurance policy and/or the time of year billing is submitted. Insurance companies do not pay all fees and may exclude certain services from coverage. If information provided by the patient's insurance company is not accurate or the insurance company changes its coverage, the patient will be responsible for payment for all services rendered. Deductible and co-payments are part of the contractual agreement with the insurance company. We are responsible for collecting those fees and are not authorized to change or waive the fees. Patients are responsible for understanding their insurance plans.

FINANCIAL AGREEMENT: **Payment for services is due on the day services are rendered, unless other means of payment are agreed upon with Comber Physical Therapy.** The patient is completely responsible for the medical treatment, including any fees charged for returned checks, regardless of any payer, third-party interest, or the resolution of any legal action or lawsuits in which the patient is involved. The patient understands and agrees that any charge which is unpaid shall be subject to a monthly interest charge of two percent (2%), and should the patient's account be assigned for collection, the patient will be responsible for all costs and an attorney's fee of thirty-three and one-third percent (33 1/3%) of all money due.

PAYMENT TERMS: Comber Physical Therapy requires patients to keep their credit card information on file with the Company. Credit card data is stored using an encrypted and tokenized system at an offsite, secure vault that exceeds all HIPAA and PCI Data Security Standards. **Acceptance of this agreement authorizes Comber Physical Therapy to debit the card on file for any patient payment responsibility, including but not limited to co-pays, deductibles, remaining balances, and no shows/cancellation fees. Outstanding balances over 30 days will be charged to the credit card on file.** A fee of two percent (2%) per month may be assessed when balances exceed 30 days. Checks returned for insufficient funds will be charged a \$50 fee.

Patient/Guardian Initials _____



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MISSED/CANCELLED APPOINTMENTS: We want to see our patients receive the most benefit from physical therapy visits or chiropractic care. During the initial evaluation appointment, a Physical Therapist or Chiropractor will provide a patient plan for care and determine the prescribed number of visits necessary to attain the agreed upon goals. Patients who adhere to their plan of care increase their ability to achieve success from physical therapy and chiropractic care by 93%, so we encourage our patients to follow the prescribed plan of care. Because cancellations and no shows affect our ability to accommodate all our patients' treatment needs, we require a minimum notice of 24 hours to avoid a cancellation fee. Monday appointments must be cancelled by end of day on the proceeding Friday to avoid a fee assessment. **If at least 24 hours-notice is not received, a \$35 fee may be charged for missing a regular appointment and a \$50 fee for a specialty appointment (including Evaluations and Women's and Men's Health).** These fees cannot be billed to the insurance and are the patient's responsibility. A pattern of no shows and missed appointments may result in discharge from our practice.

If a patient is more than 15 minutes late for an appointment, we cannot guarantee that we will be able to provide treatment.

I authorize the release of records to any agency involved in the payment of treatment for the patient named below. I authorize insurance payments to be paid directly to Comber Physical Therapy and understand that I am financially responsible for any balance.

I have reviewed both pages of the Financial Policies Agreement, and by signing below, I agree to comply with all terms contained within this document.

Patient/Guardian signature _____ Date _____

Patient name printed _____

Registered by _____ Date _____