



FINANCIAL POLICY

Thank you for choosing Kaufmann Physical Therapy as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

1. All patients must complete our information sheet.
2. **Patients are responsible for contacting their insurance company and verifying their insurance benefits including policy deductibles, co-payment, coinsurance, visit limitations, and any pre-authorized requirements.** As a courtesy, we will verify your coverage but will not guarantee the accuracy of the information we receive due to inconsistencies in insurance spokespersons. Your insurance policy is a contract between you and your insurance company. We are not a part to that contract. Therefore, you are ultimately responsible for knowledge of insurance benefits and for the full payment of your bill.
3. Co-payments and/or co-insurance are due each visit.
4. If you do not have insurance, full payment is due at the time of service unless other arrangements are cleared through our office.
5. We accept cash or checks.

Regarding Insurance

We bill insurance companies as a courtesy to our patients. However, you are ultimately responsible for co-payments, co-insurance or any part of the bill not paid by your insurance company. In trying to reduce their own costs, some insurance companies have lately developed a policy of unilaterally declaring “medical necessity has not been established” for portions of treatment. You are still responsible in this case for the services that were rendered.

In order for us to bill your insurance our patients must accept responsibility for providing the following documents:

1. A current doctor’s prescription ordering therapy, stating diagnosis, frequency and duration (updated as necessary).
2. Copy of insurance card.

Please be aware that this office will require payment in full for treatment rendered if these documents are not provided. If your insurance company fails to reimburse us within 45 days, you will be responsible for the entire unpaid balance. It is also your responsibility to check with your insurance company regarding the status of your claim.

Depending on your insurance plan, you might be required to pay a co-payment or co-insurance for services rendered. Since we will not be able to ascertain the exact dollar amount until after the insurance company processes claims, we will estimate that amount and collect that amount each visit. Once we have received payment from the insurance company, we will bill you for any amount not covered in the estimation or issue a refund check if you are in over payment. Payment is expected within 15 days of the date of the statement or a 1.5% finance charge will be assessed on all delinquent accounts.

(continued)



I understand that I am fully and completely responsible for the knowledge of my policy's benefits and limits, including number of visits, deductible amount, requirement of pre-authorization (when indicated), and co-insurance or co-payment amounts.

*****A charge or \$50.00 will be billed for any missed appointment without 24 hours notice*****

Please let us know if we can help you with any of the above information! We want you to understand your insurance policy.

By my signature below, I recognize and accept that I am ultimately financially responsible for all charges for services rendered including, but not limited to , any services or fees denied or not covered by my insurance company.

I certify that I have read and fully understand all of the above information.

Signature of Patient or Responsible Party

Date