Financial Policy

1. **Payment** is expected **at the time of your visit**. We will accept cash, check, or credit card. We do require a form of ID at the time of your first visit due to the many cases of identity theft in the news lately. (Please do not be offended). We only keep $50 of change on hand daily, so please bring appropriate cash amounts if you choose to pay that way. _____(Initial)
2. **Insurance.** We are currently out of network (OON) with select insurance companies (please speak to a representative to inquire if your insurance is in network or not) **Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full**. We will submit claims to all insurance companies with the exception of Aetna. Any claims not paid to the practice within 60 days will be billed to the patient and payment is expected within 5 days or the CC on file will be charged. In Many cases with OON Benefits, the patient will be paid directly, so any refunds due will be paid quarterly. **Any pre-authorization process that needs to be completed before your appointment is the responsibility of the patient.** _____(Initial)
3. **Assignment of Insurance Benefits for In-Network.** (Medicare, Medicaid, & Cigna) I hereby assign, transfer, and set over directly to APTaSM sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to me or my dependent in said clinic. I authorize APTaSM to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to APTaSM. I authorize APTaSM to release all medical information (including, but not limited to: information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, or other physicians or providers, and any other third-party payers._____(Initial)
4. **Returned Checks** will incur a $40.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $40 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $40 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in Arapahoe County._____(Initial)
5. **Forms Fees.** Completing insurance forms, copying medical records, etc. requires office staff time away from patient care for our Doctors. We require pre-payment for completing forms, copying medical records, or for communication. Base form charges are $10 per occurrence plus an applicable postage or notary fees. Postage is additional and payment is required in advance. Copying fees for medical records when requested by the patient are as follows: $14.50 for the first 10 pages. $0.50 per pages 11-40, and $0.33 per pages 41 and up. We have 15 days to make said copies and these 15 days will commence after payment for copying has been received and after the patient has signed this form authorizing records release. 3rd parties requesting copies have a different fee and you can find that at Health Facilities and Emergency Medical Services Division website._____(Initial)
6. **Cancellations or Missed Appointments.** You are the most pivotal piece of getting better, but like all other health issues, you need a coach. We schedule time to spend with just you in this clinic. We don't book you with an aide or PTA. If you miss that time, it takes away from another person we could be helping get back to their life. Therefore if you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $100 fee if we are participating with your insurance, or the cost of the appointment if you are part

of our concierge package. Tardiness to your appointment may (at the discretion of the provider) be counted as a no-show. Tardiness is defined as being 5 or more minutes late to any scheduled appointment._____(Initial)

7. **Accounting Principals.** Payment and credits are applied to the oldest charges first, except for insurance payments, which are applied to the corresponding dates of service._____(Initial)
8. **Responsibility for Payment.** You, as the patient, understand that you personally are financially responsible to Agility Physical Therapy and Sports Medicine for charges not covered by your insurance company for any reason._____(Initial)
9. **Statement Late Charges** of 22% annually will be applied to all patient balances 60 days or older._____(Initial)
10. **Collection Fees.** I understand that in the event my account is placed in collection status, and additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, no-shows or late cancellations, collection agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full._____(Initial)
11. **Divorced Parents of Patients.** By signing below, the adult who signs a minor child into our practice on the first day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues._____(Initial)

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of patient (or guarantor, if applicable) Date

_____ _____

Printed of patient (or guarantor, if applicable)