Patient Financial Policy

This is an agreement between South Lane Physical Therapy, LLC (creditor) and the Patient (debtor) named on this form.

In this agreement the words "you", "your", and "yours" mean the Patient (debtor). The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us" and "our" refer to South Lane Physical Therapy, LLC.

By executing this agreement, you are agreeing to pay for all services and supplies that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, and any payments or credits applied to your account during the month. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Required Payments: Any co-payments or co-insurance required by an insurance company must be paid at the time of service. We shall have the right to cancel your privilege to make charges against your account at any time and require that visits must be paid at the time of service.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay, deductible or co-insurance, you must pay that at the time of service. As contracted providers with your insurance company, we agree to accept the allowable amount (usual and customary) established by your insurance company. Although we may estimate what your insurance company may pay and the patient responsibility portion, it is the insurance company that makes the final determination of payment and eligibility.

Non-Contracted Insurance: Insurance is a contract between you and your insurance company. It is the patient's responsibility to verify if our office is a contracted or non-contracted provider. As a non-contracted provider, there is no adjustment or write-off for the difference between what we charge and what the insurance allows. You agree to pay any portion of the charges not covered by your insurance.

INSURANCE BENEFITS:

Patient Responsibility

_____ Deductible

_____ Copay / Approximate CoInsurance

Primary Insurance: If possible, we will verify your insurance benefits and eligibility prior to your first appointment. It is the patient responsibility to be aware of your own benefits and eligibility. If your insurance company notifies us that they are waiting to receive the accident report form from you, the balance is automatically patient responsibility and we will begin collection procedures. As a courtesy to you, we will bill your primary insurance; however, if our office has not received payment after 120 days, the balance will become patient responsibility unless other arrangements are made with us.

Secondary Insurance: As a courtesy to you, we will bill your secondary insurance after your primary insurance has paid. If our office has not received payment from your secondary insurance after 120 days from the date first billed to your secondary insurance, the balance will become patient responsibility unless other arrangements are made.

Referrals/Prescription/Authorization: If your insurance company requires a referral, prescription or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral, prescription and/or pre-authorization may result in a lower payment, or no payment from the insurance company.

Workers Compensation: If your claim is in deferred status, we will ask for private medical insurance to bill if your claim is denied. We require approval/authorization by worker's compensation carrier prior to your initial visit. If your claim is denied and you do not have private medical insurance, you will be responsible for payment in full. If your claim is in litigation, we do require verification of this from your attorney and/or worker's compensation carrier.

Personal Injury /Motor Vehicle Accidents (MVA): If you are being treated as part of a personal injury lawsuit or claim, we may require verification from your attorney. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred in a personal injury case. If you have Personal Injury Protection (PIP) through your motor vehicle insurance, we will bill them as primary insurance and will bill your private health insurance when your PIP benefits are used up.

The Financial Policy continues on PAGE 2

Benefit Assignment: You assign all medical benefits to us including health insurance, Medicare, auto insurance, worker's compensation or other insurance plans. You also authorize South Lane Physical Therapy, LLC to release all information necessary (including photocopies of medical records) to secure payment (see Notice of Privacy Practices). You agree that if insurance pays directly to you, this monetary amount is actually due us and is patient responsibility.

Billing Information: It is your responsibility to provide us with correct information including insurance, responsible party, date of injury, type of accident, policy and/or group numbers, etc. Should the information change, it is your responsibility to update it within a timely manner. If you supply us with incorrect information, the balance of the account at the last date of service will be entirely patient responsibility. We will not be responsible for rebilling, appealing or other dealings with newly provided insurance company.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. 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.

Methods of Payment: We accept VISA, MasterCard, personal checks and cash. There is a fee of $25 for any checks returned by your bank.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was paid by your insurance company or due by you. The **FINANCE** CHARGE will be computed at the rate of one percent (1%) per month or an **ANNUAL PERCENTAGE RATE** of twelve (12) percent. The finance charge on your account is computed by applying the periodic rate (1%) to the "past due balance" of your account. The "past due" balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. You understand that finance charges are not billable or payable by insurance.

Past Due Accounts: If your account becomes past due, we may need to take necessary steps to collect this debt. This may include contacting the person listed as the Emergency Contact on your patient data sheet. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we refer your account to a collection agency, we will add a surcharge of 30% to your balance. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs.

Missed Appointment Fee: A $25 fee may be charged for appointments cancelled with less than 24 hours notice. A $50 fee will be charged for no show or missed appointments. This fee must be paid before a new appointment is made. This fee is not billable or payable by insurance. Patients with more than two missed appointments will be discharged from therapy and referred back to their physician. We understand that emergencies do occur and will attempt to make reasonable accommodations for that.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

TYPE OF CLAIM

Is this injury due to an accident?

☐ Yes ☐ No Date of accident: _____

Was this injury due to a motor vehicle accident (either in the past or current)?

☐ Yes ☐ No

Date of injury: _____

Did this injury occur on the job?

☐ Yes ☐ No

Do you have an open worker's compensation claim? ☐ Yes ☐ No

Date of injury: _____

THIS INFORMATION MUST BE COMPLETELY FILLED OUT ON THE PATIENT DATA SHEET

I have been informed of my financial responsibility and agree to the terms and conditions as stated on this form.

Patient Name: _____ Responsible Party (if not the patient:): _____

Signature: _____ Date: _____