Payment Options

I request the following payment method:

____ **Self Payment** - I will pay in full at time of service and accept 20% off billed rates for doing so.

I will submit the billing form issued to me by Wilsonville Physical Therapy to my insurance company for reimbursement.

____ **Private Insurance** - Please bill my medical insurance company directly. I agree to pay all insurance co-payments, coinsurance, deductibles and non-covered charges at the time of service. I will pay any balance promptly upon being billed by the clinic.

My co-payment is $_____ or _____% coinsurance per visit.

____ **Workman's Compensation Insurance** - Please bill the workman's compensation insurance carrier I have listed. I will provide the claim number and caseworker's name. Additionally, I will provide information needed to bill my health insurance company, and agree to pay all charges incurred in the event that any portion of my workman's compensation claim is denied.

____ **Motor Vehicle Accident Insurance** - Please bill my auto insurance company directly. If/when my PIP coverage has been/is exhausted, I will provide information needed to bill my health insurance company, and agree to pay all charges incurred in the event that any portion of my motor vehicle accident claim is denied. ** DATE OF LOSS/INJURY: _____ (PIP expires one year after date of loss/injury.)

Please <u>sign below</u> to indicate you have read and agree to the following:

I understand that insurance plans vary in their coverage of services. I will / have familiarize(d) myself with the amount and types of physical therapy services my plan covers. I understand that if these services are not reimbursable by insurance, or should my insurance company delay or deny coverage of payment, I am financially responsible for immediate payment of services rendered. If *Wilsonville Physical Therapy* must take legal or other collections action related to my failure to pay, I will additionally be liable for the cost of collection, including but not limited to court related costs, collection fees, and attorney fees.

- I understand that I will owe **$50.00** for any missed appointment not canceled at least 24 hours in advance. Payment of missed appointment fees will be paid prior to my next appointment.
- I understand that there is a $30.00 returned check fee.
- I understand that any patient balance due is to be paid in full and received by *Wilsonville Physical Therapy* 14 days from date of first billing. A $15.00 rebilling charge will be assessed per statement if balance has not been paid within 30 days of initial billing unless other payment arrangements have been established.
- I authorize the release of any medical records or other information necessary to process my insurance claim. I request payment of insurance or government benefits be made to *Wilsonville Physical Therapy*.

_____ _____

Patient (or Guardian) Signature Date