



WELCOME TO APTA

We are dedicated to your treatment and take pride in the quality care that we deliver. In order to avoid misunderstandings we provide the following information:

As a courtesy to you, we will file insurance claims to your primary insurance carrier. All flat and percentage co-payments are the patient's responsibility and are due at the time of service. We only bill secondary insurances for Medicare patients.

Your insurance coverage is an agreement between you and your insurance company. We do not necessarily accept insurance company allowances as full payment for your account unless we are a participating provider for your plan.

Due to the volume of claims filed by our office, we are unable to follow-up on unpaid or unprocessed claims. After 45 days, any unpaid insurance claims become your responsibility. Since insurance policies vary greatly, it is **your** responsibility to contact your insurance company if you have questions regarding your policy.

Payment is expected at the time of service. We accept cash, personal checks, and major credit cards (Visa and MasterCard only). A \$25.00 fee will be added for each returned check. Should a check be returned for any reason, the patient will be responsible for the return check fee and the original payment amount.

If you are experiencing circumstances beyond your control, financial arrangements may be made with our billing office prior to your initial appointment. An annual interest rate of 18% will be applied to all outstanding balances greater than 45 days old. All account balances must be paid within 90 days or your account will be forwarded to a collection agency and a \$30.00 collection fee will be applied. All collection fees, attorney fees and/or court costs will be the patient's or patient's guarantor's responsibility if this action becomes necessary.

A \$30 office fee will be charged for missed appointments or appointments that are canceled with fewer than 24 hours notice. Insurance companies will not pay missed appointment fees.

I hereby authorize the following:

1. Treatment to myself or to the person listed on the **PATIENT INFORMATION FORM** by a Physical Therapist associated with APTA.
2. Assignment of insurance payment to APTA.
3. The release of any and all medical information to my treating physician and insurance carrier for the purpose of claims administration.
4. If applicable, I also authorize release of information to my attorney (with a signed order) and payment on my account out of funds collected.

Patient/Guardian Signature

Date of Signature