

### **Patient Financial Agreement**

We at Allied Health Solutions, LLC (AHS) look forward to providing you quality care as your physical therapy provider. Our relationship is with you and not your insurance company however we are enrolled as in-network provider with most Insurance so you the insured can avail the benefits. We also extend the courtesy of submitting claims to your insurance.

**Please read our financial policies so that your treatment process is as smooth as possible.**

#### **Billing Information**

We will attempt to verify your insurance benefits and coverage at the time you begin our professional services. It is your responsibility to provide us with your current & accurate Insurance information and also be aware of your coverage and benefits details, exclusions and limitations. **Our verification is only an estimation of insurance benefits and not a guarantee** of payment from your Insurance which will be determined after claims are processed. You are encouraged to contact your insurance company to verify your benefits and assure that your claims are being processed properly.

- In the event your insurance determines a service to be “not covered”, or you do not have the appropriate authorization or referral, you as the patient, or legal guardian, are responsible for all charges that the payer does not pay on the claim including any denials, deductibles, copayments and co-insurance due you will be responsible for the complete charge.
- In the event your insurance forwards payment directly to you, instead of to Allied Health Solutions, LLC, you are required to immediately deliver such payment with the Explanation of Benefits so we can complete the process.
- You may make payments in the office, phone, mail or online. We accept cash, check, and credit card. There is a service fee of \$35.00 for all returned checks. All accounts that are 90 days past due will be subject to interest at 3%.
- All past due accounts are subject to collection proceedings. You also understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on your account, you will be responsible for any costs and court costs, in addition to the outstanding balance. All fees including, but not limited to, collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due to this office. By signing below I am agreeing to be responsible for all cost incurred in the collection of my account.
- A \$25.00 fee will be charged to your account for appointments cancelled without 24 hour prior notice. This fee is not billable to your insurance company and is your responsibility. We appreciate your respect for other patients who can utilize your reserved time.

#### **Appointment Information**

- Your insurance may require a referral by a physician which should be provided to us on or prior to your initial visit
- It is also your responsibility to monitor the number of authorized visits for physical therapy.
- We will need a Script from your PCP and may need additional information as required by your Insurance.
- The initial visit will usually last 60 minutes with all subsequent sessions lasting approximately 45-60 minutes. Please arrive promptly for each scheduled appointment.
- Please call at least 24 hours in advance to cancel or change an appointment.

#### **Acknowledgement**

I have read and understand all of the above information, and agree to abide by all of its terms and conditions. I hereby authorize the release of any information, including medical information, requested by the insurance company for this or any related claim for reimbursement and authorize payment by such insurance company to Allied Health Solutions, LLC for services rendered. Further, I understand that I am personally responsible for all charges not covered by my insurance company.

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PRINT NAME  
Patient/Parent or Guardian

\_\_\_\_\_  
Signature  
Patient/Parent or Guardian

\_\_\_\_\_  
Date