Balanced Physical Therapy

Billing Policies

Updated: June 2016

As a courtesy to our patients, Balanced Physical Therapy will bill your insurance company if we are provided with all the necessary information. To avoid any confusion our policies are listed below.

IF YOU HAVE PRIVATE INSURANCE: _____ **initial**

(Example: Medicare, Blue Cross/Shield, UHC, Health Net, CUP....)

To ensure timely payments, you MUST identify the following information on the first visit:

A. Name of insured
B. ID number/group number and/or claim number
C. Insurance company billing address and telephone number
D. Provide Balanced Physical Therapy with a copy of your insurance card

If no payment is received from your insurance within 90 days, we will require payment from the patient to keep the account from going to collections (unless other arrangements are made).

AUTO ACCIDENT/THIRD PARTY CASES: _____ **initial**

We will bill auto insurance and other liability insurances if we are provided with the following information:

A. Name of insured
B. Claim number and Date of Accident
C. Insurance company billing address
D. Adjusters name and telephone number

If you are injured by someone else and don't have PIP coverage we will cooperate with you in processing your claim. We MAY agree to wait for payment of your bill from the proceeds of any settlement or judgment. However, you are still responsible for payment whether or not you collect from the insurance company. In cases where an attorney is involved, we require a Lien Agreement be signed to protect any balance for services provided. If your attorney refuses to sign the lien you must find other means of paying. Also, if your attorney refuses to sign the lien agreement and no payment has been made by any party within 90 days, we require a monthly payment to keep the account from going to collections (unless other arrangements are made).

ON THE JOB INJURIES: _____ **initial**

If you are injured on the job and you have an open claim we will bill the worker's compensation insurance and no payment by the patient is required. You must provide us with the following:

A. Worker's Compensation insurance company
B. Claim number and date of injury
C. Adjusters name and telephone number

If your claim is denied by worker's compensation we will bill your private health insurance-as long as you provide our office the pertinent information listed above. You are then responsible for any balance not covered.

CASH: _____ **initial**

As a courtesy to our patients who do not have health insurance coverage for whatever reason, we offer discounted rates when payment is received on the day services are provided.

PATIENT STATEMENTS: _____ **initial**

You will receive a patient statement **after** we receive an explanation of benefits from your health insurance. The services printed on the statement may not correspond with the amount that is due because we will only bill for dates of service listed on the most recent explanation of benefit. You will also receive an explanation of benefits from your insurance stating the amount you owe. If you are not insured, our staff will be glad to arrange an acceptable payment plan. No credit will be extended to patients having a delinquent account or who have been referred to a Collection Agency for payment. If this account is assigned to collections, you will be responsible for any collection cost, attorney fees and interest that may apply. Responsibility for payment of your account remains with you at all times; and although you may have an insurance claim pending, ultimately we must look to you for payment regardless of the circumstances involved. If your check is returned, there will be a $25 charge. All future payments will then need to be paid in cash. Please contact us if a problem arises.

- **LATE FEES**: _____**initial**. Any balance due will be subject to a minimum $5 handling fee or 1% per month; from date of patient statement received.

INVENTORY ITEMS: _____ **initial**

You will be required to pay for inventory items and also orthotics on the day you receive them from our office. We will bill your insurance company if requested but you are ultimately responsible for any balance due, including tax, regardless if the insurance discounts the item.

_____ _____

Signature: Patient/Parent/Legal Guardian Date

Print Name: _____