ADVANCE MOVEMENT PHYSICAL THERAPY
FINANCIAL & PRACTICE POLICIES

ADVANCE MOVEMENT PHYSICAL THERAPY is dedicated to providing the very highest level of physical therapy care and services to our patients. As a courtesy we will bill your insurance company in a timely manner. We will provide all the information necessary to process your claims in an effort to receive payment from your insurance company.

- **I am ultimately financially responsible** for the professional services that I am about to receive. **If** my insurance company does not pay for services rendered I understand that I am responsible for payment of these services.
- It is **my responsibility to understand my insurance coverage** as it relates to the services that I am about to receive. I understand that my insurance company has provided a toll-free phone number on my insurance card which I can call at any time to determine my coverage, eligibility, exclusions, deductibles, co-pays or to ask any other insurance coverage related question(s). I understand that **ADVANCE MOVEMENT PHYSICAL THERAPY** has no ability to dictate policy or procedure to my insurance company.
- I understand that **my insurance company** decides what to reimburse **ADVANCE MOVEMENT PHYSICAL THERAPY** only after bills are submitted and reviewed. **ADVANCE MOVEMENT PHYSICAL THERAPY** has no authority or ability to decide which services will or will not be paid. The amount of reimbursement for services rendered is exclusively determined by your insurance company.
- I understand that it is my responsibility to satisfy my deductible. I understand that if my deductible is not met at the time it is verified that I am required to pay cash pay rates ***($175 per session)*** until my deductible has been met. I understand that ALL co-pays and co-insurances must be paid at time of service.
- I understand that if I **NO SHOW or CANCEL my appointment** without 12 hour notice, I am subject to a ***$100 CHARGE.*** This will be due at my next appointment. There is an answering machine available for your convenience 24 hours a day. In the event of consistent no shows and cancellations my future appointments are subject to cancellation and notification to my doctor, insurance company or adjuster.
- I understand that **should I fail to pay** and am sent to collections that I will be responsible for all costs incurred in addition to the balance that is due.
- I understand that if **I am financially responsible for a patient that is a minor** and do not anticipate accompanying them to each appointment that I am required to keep a credit card or check card on file to be charged for all co-pays, co-insurances and deductibles.
- I understand that if I am a patient and need to bring a minor with me that I am responsible for their behavior & safety. **ADVANCE MOVEMENT PHYSICAL THERAPY** is in no way liable for any injuries incurred while at **ADVANCE MOVEMENT PHYSICAL THERAPY**. We do not encourage bringing children to treatment as it can interfere with the quality and efficacy of your treatment and the treatment of other patients. Should your child be disruptive to our rehabilitation setting in any way you may be asked to attend your future appointments without them.

Assignment of Benefits/ HIPPA/ Policy Agreement

I acknowledge that ADVANCE MOVEMENT PHYSICAL THERAPY has supplied me with a copy of their Office Policies and Health Information Privacy Practice Agreement (HIPPA) regarding their policies and procedures concerning my Private Health Information (PHI). I agree to release authorization to ADVANCE MOVEMENT PHYSICAL THERAPY to use my PHI as deemed necessary for treatment, billing and the other purposes stated in this document. I hereby authorize my insurance benefits to be paid directly to ADVANCE MOVEMENT PHYSICAL THERAPY. I also authorize AMPT to release any information necessary to process my claim. I have read and I agree with the above policies.

Patient or Responsible Party Signature _____ **Date** _____