THE CANTRELL CENTER
FINANCIAL POLICY

Thank you for choosing us as your physical therapy provider. We are committed to providing the best care possible for all ages and all needs in a comfortable and friendly environment. We are pleased to discuss our professional fees with you at any time. Your clear understanding of our FINANCIAL POLICY is important to our professional relationship. Please ask if you have any questions regarding fees, FINANCIAL POLICY, or your responsibility.

WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD
All returned checks will result in a $25.00 service charge

I will be paying by: ☐ CASH ☐CHECK ☐VISA/MASTERCARD
CO-PAYMENT is due at time of services (including deductibles, and non-covered services)

REGARDING INSURANCE

If you have insurance, our staff will call and verify benefits and eligibility prior to your first visit, please note that benefits given are a "**quote**" and **NOT a guarantee of payment or coverage**. Coverage and payment is determined once your insurance receives and processes your claim. As a courtesy, we will file your primary and secondary insurance. We will help you to receive maximum benefits. If you have not met your annual deductible, you will be required to pay a $160.00 deposit. You will be required to pay all co-payments, estimated coinsurance, and deductibles at the time of service or on a weekly basis. Your estimated insurance payment is based on benefits given by your insurance company. We are contracted with many insurance companies and accept the negotiated allowable fees as agreed by contract. If we are not contracted with your insurance, we are not responsible for amounts of any insurance company's arbitrary determination of usual and customary rates.

Once insurance has completed payment on your account, the balance is due in full. **With prior credit approval**, we will accept a minimum monthly payment of 20% of the total balance ***or*** $60.00, whichever is greater. Any difference from the estimated amount and the amount actually paid by your insurance company is YOUR responsibility. YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

NON-INSURANCE PATIENTS

All patients without insurance will be required to pay in full at the time of service. Credit cards, cash, and checks will be accepted.

LIABILITY ACTION-LITIGATIONS

It is your responsibility to make our office staff aware if court action on your case is a possibility. With prior approval, we will accept a letter of protection or attorney lien on third party claims. You and your attorney must sign a lien. Payment of the bill is the responsibility of the individual who receives treatment, not the individual who is being sued. A monthly payment plan will be established for you at the beginning of treatment. If claim has not settled within 90 days from discharge date, then payment must be made in full. We accept Cash, check or Visa/MasterCard.

MISSED APPOINTMENTS

It is your responsibility to notify us 24 hours prior to cancellations or rescheduling. A missed appointment or cancellation without such notice will be subject to a nonrefundable charge of $25.00 per missed appointment, which will be billed directly to the patient. This charge is not billable to commercial insurances or Worker's Compensation. Please help us serve you better by keeping scheduled appointments.

My signature below acknowledges my understanding and willingness to comply with these policies.

_____ _____ ____/____/20___
Signature Witness Date

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