

# **ANNAPOLIS FAMILY PHYSICAL THERAPY**

## **FINANCIAL POLICY**

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment.

Co-payments, co-insurance and self pay payments are due at the time of service. We accept cash, checks and credit cards. We offer an extended payment plan with prior approval. To effectively bill your insurance company we need complete and accurate insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is your responsibility to contact your insurance company regarding payments or questions regarding your medical insurance coverage.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for your area.

## **CONSENT FOR CARE AND TREATMENT**

I understand that I have been referred for physical therapy care and treatment to Annapolis Family Physical Therapy, Inc. I understand that I have the right to ask and have any questions answered regarding the treatment plan that has been prescribed for me. By signing this agreement, I consent to have Annapolis Family Physical Therapy, Inc. provide care and treatment as prescribed by my physician and/or recommended by my physical therapist.

## **INSURANCE ASSIGNMENT**

I authorize and assign payment directly to Annapolis Family Physical Therapy, Inc. for my or my child's treatment and authorize the release of medical information necessary to process the claim. I further understand that I am financially responsible for charges not covered by my insurance company. In the event payment is received by me from my insurance company, I will remit payment promptly to Annapolis Family Physical Therapy, Inc. Interest charges of 1.5% will accrue monthly for balances greater than thirty days outstanding from initial patient statement.

## **LEGAL ASSIGNMENT**

The undersigned expressly agrees that if, upon default, this matter is referred to an attorney for collection, the undersigned agrees to pay an attorney's fee of fifteen percent (15%) of the outstanding balance at the time of referral, which percentage and the amount resulting therefrom are considered reasonable by the undersigned, and any and all court costs incurred therewith.

**I HAVE READ AND UNDERSTAND THE CONTENTS WITHIN THIS DOCUMENT.**

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Patient Signature

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Date

RELATIONSHIP TO PATIENT: SELF / PARENT / GUARDIAN