ORENSTEIN
PHYSICAL THERAPY

PAYING FOR YOUR MEDICAL CARE

Orenstein Physical Therapy Financial Policy

Thank you for giving us the opportunity to work with you. We are happy to provide you with a billing office to submit all insurance claims for you. Please understand your insurance plan. This includes benefits, co-payments and deductibles. **You are responsible for contacting your insurance plan before therapy to identify what level of coverage you can expect.** Non-covered services, denied bills or slow payments by an insurance company will be billed directly to you.

PLEASE INITIAL: You will be responsible for any balance not covered by your insurance carrier.

Orenstein Physical Therapy reserves the right to suspend treatment if your outstanding balance exceeds $600.00 for more than 30 days OR if your balance is outstanding for more than 90 days. Unpaid balances 60 days and older that are the patient/guarantor responsibility, will be assessed a service charge at the monthly rate of 1.5%.

For clarification about billing and statements please contact Lori Harvey at 952-933-6724.

Required Information:

1. A signed Records Release/Assignment of Benefits form.

2. For workers compensation and auto accident claims we require the name, address, and telephone number of your employer and the insurance carrier, the date and cause of injury and the claim number. We also require your private health insurance information should your claim be denied or your benefits exhausted.

If you choose not to provide the above information, you will be held personally responsible for payment of your services.

Providing this information frees you to concentrate on getting well and permits us to work on your behalf to secure your maximum insurance benefits. Please remember that your medical policy is a contract between you and the insurance carrier. **Ultimately, payment for your medical care is your responsibility.**

PLEASE INITIAL

Cancellation Notice Policy: Please notify our office of cancellation no later than **24 hours** prior to your scheduled appointment. Failure to do so will result in a $150 service charge billed directly to you, to be paid prior to your next scheduled visit. Subsequent late-cancels or no-shows will be subject to a $150 charge and/or the suspension or termination of treatment.

PATIENT'S INITIALS _____

"I acknowledge that I have read, understand and accept the above financial policy."

_____ _____

PATIENT'S SIGNATURE DATE

_____ - PRINT PATIENT'S NAME