



924 Main Street, Niagara Falls, NY 14301

Phone (716) 282-2888 • Fax (716) 285-1281

## FINANCIAL POLICY

Thank you for choosing ADVANCED CARE PHYSICAL THERAPY, AQUATIC & FITNESS CENTER as your out-patient physical therapy facility. We are committed to your successful treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to receiving any treatment.

Please bring/wear appropriate clothing for each visit.

### **PAYMENT IS DUE AT THE TIME OF SERVICE**

We accept cash, checks, or Mastercard & Visa. Patients without health insurance covering physical therapy will need to make financial arrangements with the office manager.

### **PATIENTS WITH HEALTH INSURANCE COVERING PHYSICAL THERAPY**

As a courtesy to you, we will bill your insurance, however, we cannot do so without all pertinent insurance information. Please present your insurance identification card at your initial visit to our office. Co-payments are to be paid at the time of your visit. All charges are to be paid in full within 90 days from the date of service.

### **MEDICARE**

This physical therapy facility is approved by MEDICARE. According to Medicare guidelines, we are required to bill you for the deductible and co-insurance as well as supplies not covered by Medicare. In the event of supplemental coverage, we will handle the billing.

### **JOB SITE INJURY**

Worker's compensation pays for physical therapy treatment, however, to assure coverage the injury should be reported within 48 hours of occurrence. In the event that a claim is disallowed or goes to hearing, you and your private insurance will be responsible for payment of services rendered.

### **PERSONAL INJURY/LEGAL CASES**

If you have a legal case pending, arrangements for payment will be necessary during the litigation process. We cannot wait until the case is settled.

### **UCR (Usual & Customary Rates)**

Our practice is committed to providing the best possible treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates, unless we are otherwise contracted.

### **MINOR PATIENTS**

The parents/guardian of a minor patient are responsible for full payment. Our REGISTRATION FORM must be completed and signed by the parent/guardian before treatment can be rendered. We require a parent/guardian to be present for the initial evaluation session.

### **MISSED APPOINTMENTS**

Your treatment program has been scheduled in a manner that will afford you maximum benefit. Please make every effort to keep your appointment; we reserve the right to reschedule your appointment if you are 20 minutes late.

Thank you for trusting us with your care and please let us know if you have any questions or concerns.

***“I HAVE READ, UNDERSTAND AND AGREE TO THE PROVISIONS OF THIS FINANCIAL POLICY.”***

SIGNED: \_\_\_\_\_

DATE: \_\_\_\_\_