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FINANCIAL AGREEMENT

Thank you for choosing Choice Therapy 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. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance forms before seeing a therapist.

Regarding Insurance: We cannot bill your insurance company unless you give us the correct insurance information. Your insurance is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. All co-pays are due on the date of treatment.

Note: Medicare patients are subject to a Physical Therapy & Speech Therapy Cap which is limited to \$1840 combined for the 2 services, and an Occupational Therapy Cap limited to \$1840. This can be exceeded as long as Rehab services are medically necessary.

_____ **(patient's initials) ASSIGNMENT OF BENEFITS:** I hereby authorize and direct any insurance company to pay the proceeds of any benefits due me for services rendered by Choice Therapy directly to the provider. A copy of this can be considered as an original for insurance purposes.

_____ **(patient's initials) KNOWLEDGE AND RELEASE OF INFORMATION:** I understand the diagnosis of my problem and consent to Choice Therapy to render appropriate treatment as prescribed by my physician. Furthermore, I authorize Choice Therapy to release to my referring physician and insurance company any information including my diagnosis and records of treatment, concerning my past medical history and physical therapy.

_____ **(patient's initials) RESPONSIBILITY AGREEMENT:** I acknowledge and understand that I am responsible for all the charges for all services rendered to me or a member of my family. Although I have requested that my bill be submitted to my insurance company on my behalf, I clearly understand that it is my responsibility to make sure the bill is paid in a reasonable amount of time. If for any reason a portion of my bill is not paid by my insurance company, I further agree to make arrangements for prompt payment of the bill. I also understand and acknowledge that I am responsible for any and all additional charges incurred due to any collection efforts. I also understand that obtaining required authorization for physical therapy (and/or supplies) is my responsibility, as is any unpaid balance if this is not done. I waive any right to claim the charges for the services are unreasonable or unnecessary, as to the amount charged or the treatment rendered. I have read this entire agreement and understand it and agree to fully pay all sums charged.

_____ **(patient's initials) THERAPY PRODUCTS FOR HOME USE:** Products that are purchased for patients through Choice Therapy must be paid for upon receipt. If the product is eligible for insurance coverage, it is the responsibility of the patient to negotiate reimbursement with their insurance company.

_____ **(patient's initials) CANCELATION AND "NO SHOW" POLICY:** Appointments must be canceled 24 hours in advance. If you fail to arrive for your appointment or do not cancel 24 hours in advance, a \$25.00 fee will be added to your account per appointment. This fee is the responsibility of the patient and will not be submitted to the insurance company. This fee must be paid before patient is treated again.

SIGNATURE: _____

DATE: _____