Southwest Orthopaedic Physical Therapy

SOUTHWEST ORTHOPAEDIC PHYSICAL THERAPY FINANCIAL POLICY

As a courtesy to our patients, insurance claims (primary and secondary) are filed directly with the Insurance carriers. Our office will normally assist you by contacting and verifying your eligibility for medical benefits. Verification of eligibility and benefits *does not* guarantee payment for all services provided. Ultimately you are responsible for knowing/understanding your benefits, policy coverage, limitations, and exclusions and for paying the balance on your account.
Our office will NOT be responsible for incorrect information passed on to us by the insurance company.

You are responsible for all out-of-pocket expenses (co-pays, co-insurance, deductibles, no show fees and any non covered services that have been provided) We will estimate the co-insurance percentages based on what we expect the insurance company to pay.

Because this is an estimate and not an exact figure, there is a possibility that you will still be responsible for an additional balance and or that you may be due a credit refund if you have overpaid.

Any change in your insurance status must be reported to our office immediately, or denial of payment may result. This may resalt in balance becoming your financial responsibility.
For patients with secondary insurance, we will file as a courtesy; however, Southwest Orthopaedic Physical Therapy is bound by the primary insurance contract and follows the rules of said contract to collect all co-pays, co-insurances, deductibles at time of service. If the secondary payor pays additional funds, we will refund monies due to patient. If the secondary payor states that there are additional monies to be paid to SWOPT, the patient is still responsible for all co-pays, co-insurance, deductible and any non covered services as directed by the primary payor (with the exception of Medicaid as secondary payor). If we have not received payment from secondary insurance within 90 days, the balance may be transferred to patient responsibility and it will be up to you to pursue payment from your insurance company.

A $25 no show/cancellation fee will be charged to your account if you fail to provide 24 hours notice.
Circumstances may arise that would not allow you to provide the 24 hour notice. In this case, please

contact our office as soon as possible. We reserve the right to cancel all future appointments after 3 missed appointments.

I understand that I am financially responsible to pay my NO show/cancel fees _______Initials

ASSIGNMENT OF INSURANCE BENEFITS

I authorize my insurance company to make payment to Southwest Orthopaedic Physical therapy for services rendered to me or my insured dependent. ________Initials

If Medicare is filed, I authorize the release of any medical information or other information necessary to process claim. I also request payment of government benefits either to myself or to the party who accepts payment. _______Initials

I agree to notify this office of any changes in my insurance status or the information given this date. I understand that failure to provide updated information may result in denial of payment and will become my financial responsibility. _______Initials

I understand that obtaining prior authorization and verification of eligibility and benefits does not guarantee payment and that I am ultimately responsible for all out of pocket expenses which may include but are not limited to co-pays, coinsurance, deductibles, non covered services, no show fees, and that balances are due at time of service. _______Initials

I understand that even if I have secondary insurance, I may still be responsible for balances due as dictated by primary insurance if secondary insurance does not pay (Medicaid is the exception) _______Initials

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION REGARDING SWOPTS FINANCIAL POLICY. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY BALANCES DUE ON MY ACCOUNT.

PATIENT/GUARDIAN SIGNATURE _____________________________________DATE__________

SOUTHWEST ORTHOPAEDIC PHYSICAL THERAPY (SWOPT) PAYMENT POLICY

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I understand that it is the policy of Southwest Orthopaedic Physical Therapy to collect the balance on my account on each date of service. This balance may be due to but is not limited to co-pay/co-insurance, deductible or non-covered services. SWOPT will estimate the co-insurance percentages based on what insurance is expected to pay. Because this is an estimate and not an exact figure, there is a possibility that I will still be responsible for an additional balance and or that I may be due a credit refund if I have overpaid. _____Initials

I understand that quotes of eligibility and benefits does not guarantee payment from my insurance company for all or part of the services I receive and I am ultimately responsible for balances due on my account. _____Initials

**Please review the explanation of benefits you receive from your Insurance company and note what services are covered or non - Covered and what your insurance says is patient responsibility. Many Times some services are not covered and you are responsible for those Amounts in addition to your coinsurance or co-payments. Oftentimes Patient will receive insurance statement before swopt does so this Should provide you time to decide if you would like to continue Receiving non covered services. If not it is your repsonsibility to Notify your therapist services are not being covered and discuss Other treatment options.*

If I am unable to pay my entire balance due on each day of service I agree to pay 50% or greater of my balance as a deposit toward my total out-of-pocket responsibility. _____Initials

If unable to pay my balance at time of service, my future appointments may be cancelled or rescheduled after the 3rd unpaid appointment, unless a payment plan is arranged with the billing office department. _____Initials

I understand that I will also be billed for any outstanding balance, until my account is paid in full. _____Initials

Patient/guardian signature_____Date_____

Consent for Photography/Videotaping for publicity and or publicity and Marketing

Patient's Name: _____

I hereby give my consent to have photographs, videotaped images, or other images made of myself or my family member and/or consent to interviews with a member of the SWOPT staff. I understand and agree that these images may be used by the news media (in the case of a press release) or by SWOPT for the purpose outlined below: Documentation, marketing, publicity, advertising, website, social media marketing, and patient progress.

Signature of Patient or Legal Representative _____

Date Signature of Witness Date_____