FINANCIAL POLICY

This is an agreement between Personal Edge PT, Inc., as creditor, and the patient/debtor named on this form.

In this agreement the words “you”, “your”, “yours” mean the patient/debtor. The word “account” means the account has been established in your name to which charges are made and payments credited. The words “we”, “us”, and “our” refer to Personal Edge PT, Inc.

By executing this agreement, you are agreeing to pay for all services that are received.

Patients with Insurance: It is your responsibility to know your insurance. It is impossible for us to know each individual plan. You must be aware of your co-pays, co-insurances, share-of-cost and annual deductibles. Please note: Authorization from your insurance company whether written or verbal are not a guarantee of payment. Final coverage and payment determination is made after the claim is submitted.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a copay or deductible, you must pay at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain referral and/or pre-authorization may result in lower payment from your insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charge not covered by the insurance. If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in lower payment from your insurance company.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show charges by date of service, payments, or credits applied to your account, and finance charges if any.

Financial Charges: A finance charge will be imposed on each item of your account which has not been paid within sixty (60) days of the time charges were incurred. The finance charge will be completed at the rate of one percent (1%) per month or an annual percentage rate of twelve percent (12%). The finance charge on your account is computed by applying the periodic rate (1%) to the “overdue balance” of your account. The “overdue balance” of your account is calculated by taking the balance owed sixty (60) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum finance charge is $.50.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days.

Payment Options: We accept cash, check, Visa, MasterCard, American Express, and Discover. If you choose not to sign our financial policy, payment in full is due at the time of service. We will then give you a detailed receipt for you to submit to your insurance company for reimbursement.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have referred your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer the collection of the balance to a lawyer, you agree to pay all lawyers’ fee which incur plus all court costs.

Returned Checks: There is a fee (currently $35) for any checks returned by the bank.

Missed Appointment Fee: The second time a patient does not show up on time for an appointment, or cancels with less than 24 hours’ notice, a $30 fee will be charged. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be asked to transfer their care to another facility.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Effective Date: Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Patient Name:	**Responsible Party (if not the patient):**

Signature:	**Date:**