PHYSICAL THERAPY CENTER OF TUSTIN INC.

Brett Eirich, PT, ATC

FINANCIAL POLICY

Regarding Insurance: You should know that the Physical Therapy services are provided directly to you, and not to an insurance company. Thus, you are ultimately responsible for the bill, not the insurance company. Many people fail to realize that if the insurance company does not pay the bill for any reason, they are still responsible for the bill. It is the person's responsibility to get his or her own claim, our office uses a standardized medical accounting system. The bill you are given, when attached to your insurance claim form, is accepted by the insurance companies as the doctor's portion of the claim form. However, as a courtesy to our patients, we will bill your insurance company for you. It the insurance company has failed to pay within a 90 day period, we will expect you to pay the balance of your bill in full and collect from your insurance company.
We will notify you of your responsibility of payment. We ask that you pay on a weekly basis, your last visit of each week.

Special Needs: are understood by us. It may be necessary to set up a payment plan for a patient requiring lengthy treatment. If this situation is necessary for you, please bring the matter up as soon as possible.

AGREEMENT TO PAY

I hereby understand and agree that I am totally responsible and liable for payment of all charges assessed for professional services rendered to me or my dependents and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance as a matter of convenience only and that I am ultimately responsible for all charges regardless of my existing medical coverage. In the event that my insurance company forwards payment directly to me instead of to Physical Therapy Center of Tustin, I will immediately deliver such payment to the above named facility. I understand and agree that if it becomes necessary to commence legal action for the collection of any charges on my account I will be responsible for any cost, fees, or court charges in addition to the outstanding balance.

CONSENT TO TREAT

I hereby consent treatment to myself and/or my dependents, if under the age of 18.

APPOINTMENT CANCELLATION / NO SHOW POLICY

We understand individual schedules may vary and emergencies may occur; however, we appreciate twenty-four (24) hours advanced notice in the event of a cancellation. Failure to do so may result in a **$40** charge. I hereby understand that it is my responsibility to notify Physical Therapy Center of Tustin twenty-four (24) hrs in advance of any change/cancellation of appointment to avoid any cancellation charges.

_____ Patient Initial

AGREEMENT FOR HMO PATIENTS

I hereby understand that as an HMO patient, I am responsible for an established office visit co-payment (if applicable) at the time services are rendered. I also understand that any supplies given in the office are to be paid in full by myself and not to be billed to my insurance company.

_____ Patient Initial

_____ Patient Signature

_____ Date

_____ Insured/Parent/Guardian Signature

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