HealthWorks Physical Therapy Specialists Financial Policies

Your insurance company may require you to pay a co-payment for physical therapy at the time of service. Many insurers list the co-payment amount on the card beside the OV (office visit). In some cases, physical therapy will fall under the "Specialist" co-payment listed on the card. In other cases, the co-payment may not be on the card at all. We will call to verify benefits prior to your first appointment. We encourage you to review your policy before you start physical therapy.

Our Co-Payment Policy is as follows:

1. Co-payments are due at the time of service provided.
2. We accept cash, checks, credit cards and debit cards. Upon request, you may have your debit/credit card information kept securely on file.
3. We do not bill for co-payments. It is the patient's responsibility to stay current with co-payments.
4. Patients under the age of 18 must have a parent or guardian sign this form. It is the parents or guardians responsibility to stay current with co-payments.
5. A minimum payment of $15.00 per visit is required prior to treatment from patients who are **Litigation (car accident, liability etc.).**
6. For patients who choose our **Prompt Pay option** (due to high deductible, no insurance, HSA, or other reasons) a 40% discount is available. Full payment is required at each visit. Billing of insurance will be your responsibility.

Responsibility for the full charges of your physical therapy services are yours. It will be necessary for you to make the proper arrangements to handle the uninsured portions of your charges. As a courtesy to you, we will file your primary insurance free of charge on our standard form, provided all necessary information is given. If your company requires special, additional forms to be filed, you will be charged a filing fee of $20.00. There is a $20.00 fee on all returned checks. If you are unable to abide by the above policy, please make arrangements with our office staff.

The statements contained herein are true and complete to the best of my knowledge. I understand fully the payment policy and billing procedures of HealthWorks. I hereby authorize HealthWorks to furnish my insurance company, attorney or legal representative all information which said parties may request concerning my present illness, injury or condition.

I hereby assign to HealthWorks, all money to which I am entitled for medical expenses relative to the service reported herein, but not to exceed my indebtedness to HealthWorks. It is understood that any money received from the above-named parties over and above my indebtedness, will be refunded (either to me or my insurer, whichever is the source of the over-payment) when my bill is paid in full. I understand I am financially responsible to HealthWorks for charges not covered by my insurance company. I certify by my signature that I have read and agree with this information. I also certify that I consent to evaluation and treatment by the staff of HealthWorks.

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

****Important Notice: Cell Phones are not allowed in HealthWorks Treatment Areas. Please turn off your cell phone or leave it in your car. Thank you for your cooperation.**

_____ _____ Date _____

Patient's Name (please print) Patient's Signature

_____ _____ Date_____

Parent's/Responsible Party's Name (please print) Parent's/Responsible Party's Signature (if applicable)