**The Family Practice & Orthopedic Care Center, PC / Omega Physical Therapy**
**Statement of Patient Financial Policy**

**Patient Name: _____ DOB: _____**

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that the payment of your bill is part of this treatment and care as well as your financial responsibility. This responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will attempt to verify your coverage and bill your insurance company on your behalf; however, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payments/co-insurances as determined by your contract with your insurance carrier. Per your insurance contract with your provider and our office policy we expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for knowing those stipulations and for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, you will be responsible for payment of your balance in full within 30 days. As a convenience, we accept Visa, MasterCard, Discover, and American Express, along with personal checks and cash. A $25.00 fee will be charged for all returned checks. If unable to pay your account balance in full, payment arrangements can be made affording you 3 (three) months in which to pay your balance in full. Unpaid balances and/or bad debts unpaid greater than 6 months will be turned to Collections, and termination of patient care will be exercised per written policy.

**Cancellation/No-Show Policy:**

We reserve the right to charge $25.00 for no show/no call missed appointments and $40.00 for New Patient appointments/Physical exams that are missed. We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, **we urge you to call 24-hours prior to** your appointment so we can serve another patient. By signing below you are acknowledging that you are fully aware and understand this policy, as well as understanding that if you no-show for three appointments, you are subject to being discharged from the practice.

**Late Arrivals:**

Late arrivals may be asked to reschedule their appointment. The decision is at the discretion of the performing Provider.

**Self-Pay ( No Insurance):**

Patient without health insurance will be required to pay $150.00 deposit upon check-in and make payment arrangements with our Patient Accounts Representative.

**Auto Accidents:**

We accept auto insurance payments including your benefit under PIP (Personal Injury Protection) with any remaining balance being your responsibility. It is your responsibility to provide us with all billing information needed to process your claim.

**Workers' Compensation:**

We will provide care in Worker's Compensation cases only if we have prior approval from your employer/carrier. If a claim is denied and you have other insurance, we will attempt to bill your insurance. However, if insurance does not cover your balance, you are responsible for prompt payment of any outstanding balance within 30 days.

**Fees: <u>There will be a $5.00 Billing Fee on any unpaid balances over 60 days. Balances due are to be PAID in FULL within 90 days (3 months)</u>**

**Prescriptions:** There is a 72 hour prescription refill policy, refills needed on an urgent/same day basis will be subject to a $10 stat fee.

**Form Fee:** $15.00 for single page forms and $25.00 for multiple page forms, which is due prior to the form being completed.

**Patient Records:** $20.00 fee for first 20 pages, with 0.50 additional for pages 21-50, and greater than 50 will be charged additional 0.20 per page. However, there will be no charge for records when referred by our office to another physician.

**I have read and understand the above information and I agree to the terms.**

**Patient/Guarantor Signature: _____ Date: _____**