CORE PHYSICAL THERAPY

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# FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. However, it is not a guarantee of payment. Please provide Core Physical Therapy with your current insurance carrier prior to treatment and notify us if there are any changes in your insurance. Benefits are determined at the time the claim is processed. You are responsible for the entire bill when the services are rendered unless prior arrangements have been made. We require that arrangements for payment or your estimated share be made at the time of service. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit to Core Physical Therapy. The above does not apply for those patients treated under Worker's Compensation. However, be advised that if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that my account, if paid within 30 days of my discharge, will be interest free. After 30 days, my account will be subject to an 18% interest (APR) fee. If I fail to make any payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. I understand and agree there will be a $35 service charge for all returned checks. If I have indicated, "paid in full" or similar endorsement on my check and a balance remains on my account, I agree that this remaining balance is still my responsibility.

NOTE: Estimated coverage information is provided as a courtesy to you, but is not intended to release you from total responsibility for your account balance.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient: _____ Date: _____

Patient/Guardian/Responsible Party: _____ Date: _____

Witness: _____ Date: _____