ADIRONDACK PHYSICAL THERAPY AND SPORTS REHABILITATION, P.C.

Financial and Billing Policy

In order for us to bill your insurance company accurately, you are required to provide us with all of your insurance information. All claims will be submitted to your insurance company on a weekly basis. Your insurance policy is a contract between you and your insurance company and you are ultimately responsible for making sure that all covered benefits are paid.

You will receive a statement each month informing you of any unpaid balance. Balance is due upon receipt of statement. We offer several payment options outlined below.

Payment Options for Co-payments/Patient Payments

We accept **CASH, PERSONAL CHECKS, MONEY ORDERS, AND CREDIT CARDS (Mastercard and VISA)**

* Once again, we will bill your insurance company for you as long as accurate information is made available for us to bill.

If you do not have insurance coverage, we appreciate payment in full at the time of service.

If none of these options are convenient for you and you need to be put on a payment plan, please ask to speak to our billing personnel today.

We ask that all co-payments be collected at the time services are rendered and deductibles once your insurance company has processed your claim.

If we are not notified **24 hours** in advance of cancellation, a **$10.00 fee** will be assessed. Patients who fail to show for or cancel 2 or more appointments, may be discharged from Adirondack Physical Therapy at the physical therapist's discretion.

Authorization and Assignment of Benefits

I authorize Adirondack Physical Therapy and Sports Rehabilitation, P.C. to release any and all information concerning my treatment to all insurance companies for claims submitted and to verify employment or insurance coverage for myself/or spouse/dependents. I also authorize the payment of any insurance benefits directly to Adirondack Physical Therapy and Sports Rehabilitation, P.C.

I understand the financial policy explained above and acknowledge that the fees for services rendered are my responsibility.

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Signature of Patient/Responsible Party Date