Financial Policy for SCORE, LLC

Thank you for choosing SCORE, LLC as your physical therapy provider. We are committed to your treatment being successful. The following is a statement of our financial policy that we require you to read and sign before services are rendered.

You are ultimately financially responsible for the medical services you receive. We bill your insurance, but it is your responsibility to provide us with accurate and up to date information.

You are responsible to know your physical therapy benefits. SCORE, LLC will provide you with the benefit information we received from the insurance company but SCORE, LLC cannot guarantee that the information obtained is accurate. Please contact your insurance company directly for your benefit information and any clarification you may need.

Co-Payments: Stop at the front desk to pay your co-pay before starting treatment. If no one is at the front desk please give payment to your therapist.

Deductible/Co-Insurance: A deductible is the amount that your insurance requires you to pay directly to providers before your insurance company will pay its portion of the benefit. A co-insurance is a percentage of your charges that you will pay. Your charges may differ from visit to visit because it depends on which procedures were performed that day. Because your co-insurance is a percentage of that total charge, the amount you pay per visit may differ as well. We calculate total charges based on the contracted fees that we have with your insurance company, so an adjustment is made before collecting your percentage. Some insurances have a flat, per visit rate for physical therapy services. In these instances, your percentage would result in the same fee each visit because the visit charge does not vary based on procedures performed.

If your deductible or co-insurance has not been met, we will estimate the deductible or co-insurance amount based on what we have been lead to expect from your insurance company. Please note that any payment made on the date of service is considered a deposit toward your estimated balance. Because this is an estimate, there is always the possibility that you may either be responsible for an additional balance or due a refund. If a refund is due- it will be promptly provided. If it turns out your insurance company paid less than expected and you are responsible for a higher portion we will bill you the difference.

Visit Limits: Some plans specify a limit on the number of physical therapy visits allowed per year. Sometimes this is combined with physical, speech, occupational and chiropractic services. It is each patient's responsibility to keep up with the number of visits that have been used. Once you have exhausted your visit limit, your insurance company will not pay for additional visits.

Returned Checks: There is a $20 charge for all returned checks.

Patient Statements: If there is a remaining balance on your account, we will send you a statement.

Payment Plans: Our office will be happy to assist you with a payment plan. However, the payment plan must be made in advance and in writing.

Collections: If my account is turned over to a collection agency or attorney I agree to pay for all costs of collections, including any processing fees.

Workers' Compensation: It is your responsibility to provide our office with all information necessary to obtain authorization for your services. If your claim is denied, you will be responsible for payment in full.

Auto and Personal Injury Claims: It is your responsibility to provide our office with the correct claim and billing information pertaining to any auto or personal injury claims. If med-pay coverage is available we will bill the auto insurance directly.

Self-Pay: If you are not insured, payment will be expected in full at the time of service.

Minor Patients: If your minor child will be attending therapy without you, please send in payment with them. The adult consenting treatment is financially responsible for all services rendered.

Cancellations & No Shows: If you do not call to cancel your appointment there is a $65 no show fee (not covered by insurance).

By signing this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. Altering this form in anyway will not change the policy as outlined above by SCORE, LLC.

Patient Name: _____ Date of Birth: _____

Signature of Patient/Responsible Party: _____ Date: _____