MONTCLAIR
PHYSICAL THERAPY & WELLNESS

6125 Medau Place ■ Oakland, California 94611 ■ 510.339.2116 ■ Fax: 510.339.0647 ■ www.montclairpt.com ■ clinic@.montclairpt.com

Financial Policy

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. ***Your clear understanding of our Financial Policy is important to our professional relationship.*** Please ask if you have any questions about our fees, our policy, or your responsibility.

PRIMARY INSURANCE: We file claims as a courtesy to you. However, if we do not receive payment within 90 days, you will be held responsible. The full balance is due upon receipt of invoice. ***We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary to secure payment of a claim. Co-payments and deductibles are due at time of visit. You may also be billed for non-covered charges.***

AUTOMOBILE MEDICAL INSURANCE: We will bill your automobile insurance company for your treatment provided that you have auto med-pay coverage with your policy. If you do not have auto med-pay, payment is due at the time of your treatment. We will provide you with documentation in order to facilitate reimbursement upon settlement of your case.

WORKERS COMPENSATION: We will bill your workers compensation carrier for your charges. In the event of claim denial or fraud, you will become financially responsible for all treatment charges.

CASH CUSTOMER: Please pay the balance in full at the time of service or upon receipt of invoice. Failure to maintain these arrangements may result in the placement of your account with an agency for collection.

CANCELLATION POLICY: We require 24-HOUR notice for cancellation of a scheduled appointment. Failure to comply with this policy will result in a $25.00 charge. This charge will be billed to you directly.

I authorize the release of any medical or other information necessary to process this claim. I authorize payment of medical and, if applicable, government benefits to Montclair Physical Therapy & Wellness. I assign all payments for physical therapy services to Montclair Physical Therapy & Wellness.

I agree that I am responsible for payment of my physical therapy invoices, whether or not my insurance company is paying them. I agree to pay for attorney's fees, legal fees, court costs, and any costs incurred in the collection of delinquent accounts. I agree to pay charges for appointments not cancelled 24 hours in advance. Payment is due upon receipt of invoice. A 12% per annum charge will be added to any invoice that has been left unpaid past sixty days.

Please sign and date this form to indicate that you understand and agree to all of the terms of the payment policy described above. ***Please let us know if you have any questions or concerns.***

Signature of Responsible Party _____ **Date** _____

According to your insurance, you have a $_____ co-payment per visit.

(You are required to pay this amount upon your arrival for each visit.)