CLINIC FINANCIAL POLICIES

Thank you for choosing Alpine Physical Therapy (APT) for your rehabilitation needs. We appreciate that you have entrusted us with your health care and are committed to providing you with the best care possible. Healthcare benefits and coverage options have become increasingly complex, so please let us know if we can help you better understand your responsibilities as a patient. Please carefully read through the following information.

UPDATES: It is important that we have your correct information on file. Please advise us anytime there is any change to your address, telephone or other contact information. If you are issued a new insurance card please allow us to take a copy of it for your file. If your insurance changes or discontinues mid-treatment, please notify us immediately so there is no delay in billing.

PATIENT PRIVACY: Alpine Physical Therapy is committed to protecting the privacy and security of our patients and all Protected Health Information (PHI). During the course of treatment it may be necessary to share information with other medical providers. We follow all Federal and State regulations regarding PHI and information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual as provided by law. If requested, we can provide you with a copy of our "Notice of Privacy Practices".

INSURANCE COVERAGE: As a service to our patients, Praxis Medical Group dba: Alpine Physical Therapy & Spine Care will bill your insurance for services rendered, but it is our policy that the patient is ultimately responsible for payment of the services received from APT. Furthermore, the patient is responsible for understanding their insurance coverage in relation to covered services and is responsible for providing APT with the most current insurance information. We make every attempt to verify your current insurance coverage, although verification of benefits is NOT a guarantee of payment. ***Deductible and Co-payments are part of your contractual agreement with your insurance company and it is our responsibility as participating providers to collect those fees. Co-payments are due at each visit. If your insurance company reimburses more than the billed amount we will reimburse you immediately upon overpayment.***

_____ **INITIALS REQUIRED IF COVERED BY MEDICARE**: ***Physical therapy is a covered service through Medicare, for treatment deemed medically necessary, up to $2010 for 2018 (approximately 18 visits).***
Our therapists are participating providers with Medicare, and we will attempt to bill Medicare as well as any supplemental insurance provided. You are financially responsible for any co-insurance or annual deductible as applicable.

****If you have had previous physical therapy treatment elsewhere prior to your visits with us, please notify the front desk so we can adjust your treatment plan appropriately.****

AUTHORIZATION FOR TREATMENT & FINANCIAL RESPONSIBLITY

I authorize treatment of the patient named below and understand I am financially responsible for all charges whether paid by insurance or not. I assign directly to Praxis Medical Group, DBA Alpine Physical Therapy all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize the use of this signature on all my insurance submissions.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Praxis Medical Group, DBA Alpine Physical Therapy & Spine Care to release my health care information or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

I authorize my healthcare providers to release personal health information as it pertains to my rehabilitative care if any is requested by Alpine Physical Therapy & Spine Care.

PRINT NAME:_____

SIGNATURE: _____ DATE: _____

ALPINE
Physical Therapy & Spine Care

24 Hour Cancellation Policy

We realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable. However, advance notice allows us to fulfill other patient's scheduling needs and keeps the clinic operating at is most efficient level. Due to our one-on-one, 60-minute treatments, missed appointments are a significant inconvenience to your physical therapist, the clinic and other patients.

This policy is in place out of respect for our therapist AND our clients. Cancellations with less than 24 hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot, and leave a 60-minute hole in your therapist's schedule.

1. ***Please provide our office with 24-hour notice to change or cancel an appointment.*** Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for a $50.00 service charge. This charge cannot be billed to insurance and will be applied directly to your account as your financial responsible.

2. We reserve your one-hour appointment time just for you. We do not double-book our patients so that we may provide optimum treatment outcomes for all our patients. 24-hour notice allows us to offer that time to a wait-listed patient.

3. Accident claims adjusters expect regular attendance to physical therapy as a requirement of an approved treatment plan. If appointments are missed or cancelled on a regular basis it could affect the status of your claim. Your treatment plan has been established by your medical practitioner(s) to get you back to your regular activities as quickly as possible. Missing appointments hinders that process and may end up prolonging recovery.

4. After two missed or cancelled appointments without the appropriate 24 hour notice, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance.

NOTE: *You will never be charged for a cancellation if it is made more than 24 hours in advance of your scheduled appointment time, or should an emergency or inclement weather inhibit your ability to attend your appointment.*

Thank you for providing our office and our patients with this courtesy.

I have read, understand, and agree to abide by the policy above:

Print Name: _____

_____ _____

Signature of Patient (or Responsible Party) Date