EXPERIENCE EVERY DAY.

Alpine Physical Therapy

CLINIC FINANCIAL, CANCELLATION AND PRIVACY POLICIES

INSURANCE COVERAGE AND PAYMENT

During your first visit we will attempt to verify your insurance coverage online. Verification of benefits is not always accurate nor is it a guarantee of payment by your insurance plan. We recommend you also familiarize yourself with your physical therapy benefits through your insurance plan. Any questions you have regarding coverage or benefits should be directed to your insurance company. We bill each date of service individually and your insurance will process each claim and assign a portion of the bill as your financial responsibility. Our website provides a link for you to log in and check your balance due and make a payment in required. In addition, we will send an itemized statement each month showing your financial responsibility. Payment in full is required within 30 days unless arrangements are made through our billing dept. We offer a 6-month interest free payment plan option should it be needed, but as a small business we cannot carry long term patient balances beyond that time frame.

COPAYS are due at each visit. Deductibles and co-insurance are part of your agreement with your insurance company, and as participating providers it is our contractual obligation to collect those fees

COLLECTIONS

You are ultimately responsible for the payment of your bill and agree to pay for services and supplies provided within the scope of your treatment. Any account that ages beyond 90 days without a payment will be transitioned to a collection agency. Should that happen you may be charged a one-time fee of $50 at the time of assignment.

MOTOR VEHICLE ACCIDENTS AND WORKER'S COMPENSATION

It is your responsibility to provide us with your insurance carrier information and claim number. If your claim is denied for any reason we will attempt to bill your private health insurance. Ultimately, however, you are financially responsible for the medical care you receive. We do not bill Third Party insurances (another person's insurance), so please discuss the specifics of your claim with the front desk, especially if your accident occurred out of state, so we can ensure proper billing and reimbursement. We do not accept letters of protection from attorneys to cover claims in dispute or litigation.

MEDICARE

Physical therapy is a covered service through Medicare, for treatment deemed medically necessary, up to $2410 for 2025 (*approximately 20 visits*). We will bill Medicare, as well as any supplemental insurance you've provided. You are financially responsible for any remaining co-insurance, annual deductible or non-covered services as applicable.

*****PLEASE NOTE: If you have previously attended physical therapy in this current year with another clinic or are currently being treated at another location for a separate issue, please notify the front desk so we can make the required notations to your account.***

CANCELLATION POLICY

TO CANCEL AN APPOINTMENT, PLEASE NOTIFY US PRIOR TO 3PM THE DAY BEFORE YOUR APPOINTMENT

Patients who miss a scheduled appointment or fail to notify the clinic before 3pm the business day prior to change or cancel an appointment may be charged a $100.00 fee. This charge is not reimbursable by your insurance and will be applied directly to your account as your financial responsibility.

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

****OREGON HEALTH PLAN**:** Does not allow us to charge its members a no-show or cancellation fee.
If you are covered by an OHP policy and fail to show up for a session or don't provide sufficient notice to cancel an appointment we will immediately enforce the same-day scheduling policy and no future appointments will be scheduled.

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PRIVACY POLICY

We are dedicated to protecting the privacy and security of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your Protected Health Information (PHI) is never compromised is a principle concept of our practice. During the course of treatment, it may be necessary to share information with other medical providers, but your PHI will never be given to anyone, even family members, without your consent. We follow all Federal and State regulations regarding PHI and information will only be released with a written authorization.

The **Notice of Privacy Practices** describes the uses, disclosures and practices followed by APT staff and your rights regarding your health information. You have the right to receive and review a written description of how Alpine Physical Therapy will handle your PHI, simply request a copy from our front desk.

The **Health Insurance Portability and Accountability Act (HIPAA)** gives you the right to request that we communicate financial and/or medical information to you in confidence.

In order to protect the privacy and confidentiality of your information please complete the following:

☐ I give permission for APT to leave messages regarding my appointments, treatment or billing information to the following: Phone _____ E-mail _____

☐ Do Not Leave A Message

☐ And/or with the following person should I be unavailable:

Name: _____ Relationship: _____ Phone: _____

CONSENT FOR TREATMENT

I consent to all services ordered or deemed appropriate by my physician or my physical therapist. I understand the practice of physical therapy is not an exact science, and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand that I have the right to ask questions at any time during the course of my care, and that I may refuse treatment or services at any time. I understand Alpine Physical Therapy does not guarantee any outcome for any services or treatment, either stated or implied.

ASSIGNMENT OF INSURANCE

I hereby assign Alpine Physical Therapy my rights and claims for reimbursement under my health insurance policy. I authorize direct payment of medical benefits to Alpine Physical Therapy and Wellness Center Inc.; however, I fully understand that I am financially responsible for all therapy services regardless of the insurance or claim benefits.

RELEASE OF MEDICAL INFORMATION

I authorize the release of pertinent medical information to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits. I also authorize other healthcare provider(s) involved in my coordination of care to release personal health information as it pertains to my rehabilitation if any is requested by Alpine Physical Therapy.

By my signature below I certify that I have read, understand and agree with the policies listed in this document and sign freely and voluntarily.

Patient's Name (please print) _____ DOB: _____

Patient or Responsible Party Signature _____ Date _____