FINANCIAL POLICY

Specialized PHYSICAL THERAPY
www.SpecializedNJ.com
(201) 773-8851

ALL PAYMENTS ARE EXPECTED AT THE TIME OF SERVICE

Initials _____ (for the information below)

Please note, all Patient Responsibility Payments are due at time of service unless other arrangements were made prior to initial appointment. This includes all deductible, co-insurance, and co-payment amounts.

Also, please note that payments made at time of service are for an estimated amount based on benefit information provided by your insurance company, and not the exact amount you will owe for any given date of service. Final dollar amount due for services will be determined after your insurance processes your claim. The clinic accepts cash, personal checks (in-state only), VISA, MasterCard, American Express, and Discover. There is a $25.00 service charge for returned checks. All patients are required to supply the clinic with a valid credit or debit card prior to their first visit to ensure timely payment of insurance non-payment and owed amounts.

Patients with an outstanding balance 90 days or older authorize the clinic to charge their credit or debit card on file for the balance due. If we are unable to collect payment from your debit or credit card on file we may forward your account to a third party collection agency. Please note we will not book any additional appointments until your balance has been paid in full.

INSURANCE

Initials _____ (for the information below)

Our office will check your benefits as a courtesy to you and provide this information on or before your first appointment. The benefit information we will provide for you is only a quote of benefits, so it is not a guarantee that we will receive payment from your insurance company for services rendered. The actual benefit for services provided will be determined by your insurance carrier once they receive your claim.

We bill participating insurance companies as a courtesy to you. You are expected to pay your deductible, co-insurance, and/or co-payment at the time of service. If we have not received payment from your insurance company within 90 days of the date of service, you may be expected to pay the balance in full. Please note, even though we will bill your insurance carrier, you are still responsible for payment of all services rendered whether by you or your insurance company.

Cancellation Policy

Together, you and your therapist will set your treatment goals and time frames to complete these goals. It is important that you attend all scheduled treatment sessions to achieve the best success. If you must cancel or change an appointment, we request that you give us 24-hour notice prior to your scheduled appointment time by calling 201-773-8851. There will be a $40.00 cancellation fee that is not reimbursable by your insurance company if we are not given 24-hour notice. If you are a worker's compensation patient, please be advised that your employer, physician, and rehabilitation nurse/adjustor may be notified of each missed appointment.
I acknowledge that I have read and understand this cancellation policy.

REFUNDS

Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances unless a written request for refund is received. Amounts $20.00 and greater will automatically be refunded to the patient/guarantor.

I have read and understand the Clinic's Financial Policy. I agree to assign insurance benefits to the Clinic's Practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I may also be responsible for the fee charged by the collection agency for cost of collections.

Signature _____ Date _____