Physical Therapy Center of Rocky Hill

___ _ **PRIMARY INS. :** We will bill your primary insurance as a courtesy to you. **We assume payment of insurance benefits is not forthcoming on charges older than sixty days.** Any remaining balance after your co-pay and your primary coverage has paid, including items classified as "above usual and customary" , is due from you upon receipt of the explanation of benefits from your primary insurance carrier. ***Prior to beginning treatment, we will verify your insurance benefits. While we will take all reasonable action to provide accurate therapy benefit information for your specific plan, be aware that verification of benefits is not a guarantee of payment from your insurance carrier.***

____ **MEDICARE:** We will bill Medicare for you. In most cases, Medicare will pay 80% of allowable charges. We will bill your secondary insurance for you, if you have one, or the balance will be billed to you.

____ **WORKERS' COMP:** We will bill your Workers' Comp. carrier for your charges. Please note that you will remain financially responsible for all of your charges if your carrier denies coverage.

____ **SELF PAY:** Please pay the balance in full at the time of service or upon the receipt of a monthly statement or notice. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Please be advised that Physical Therapy Center of Rocky Hill is not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with a collection agency or attorney for collection. Credit Cards (Mastercard, Visa and Discover) are accepted for payment on account.

Please be aware that you will remain financially responsible for services rendered regardless of the payment option selected above. In the event your account becomes delinquent and is therefore in default of payment, the patient, legal guardian, or admitting parent will be responsible for the principal amount owing, and all reasonable costs associated with the collection of this debt, including, but not limited to, collection service fees, attorney's fees, and all court costs and additional legal expenses associated with the recovery of this debt. We reserve the right to charge interest on balances over thirty days old, charge returned check fees of $20.00 as allowed by state law.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please ask for our assistance. Kindly sign and date this document to indicate that you understand and agree to the terms of this payment policy.

SIGNATURE: _____ DATE: _____