Potomac Square Family Medicine Physical Therapy
Financial Policy

Thank you for allowing our physical therapy providers to be a part of your healthcare team. We are committed to providing you with high quality treatment and ask that you read and acknowledge the terms of our financial policy.

PAYMENT: All payments including copay, coinsurance and deductible are due at the time of service. We accept cash or Visa, Master Card, Discover, American Express credit card/debits cards. Payment plans are available and must be set up in advance.

COINSURANCE/DEDUCTIBLE: If you have not met your plans deductible or out of pocket maximums, we will estimate based on our contracted rates, the amount you will owe for services rendered. This estimated amount will be due at the time of service. Please understand this is only an **ESTIMATE**. Once your claim is finalized by your insurance, we will send you a statement for any additional amounts owed. Additional amounts due will be collected at your next appointment.

INSURANCE: We will contact your insurance prior to services for coverage and benefits. Please be aware that a quote of benefits is not a guarantee of payment. **We encourage you to contact your insurance for detailed benefits and coverage.** Physical Therapy benefits are subject to visit limitations. These visits typically reset each calendar year and include other outpatient therapies such as: acupuncture, chiropractic or occupational therapies. Ultimately you are responsible for knowing your level of coverage. Claims denied related to visit limitations will be your responsibility. You will be expected to pay the cash pay rate of $85 per visit for denied claims.

CANCELLATION POLICY: If you are unable to keep your therapy appointment, we kindly ask that you give us 24 hours notice. Failure to cancel with notice or "No show" for a scheduled therapy appointment may result in a $50 fee assessment.

My signature below confirms I have read and understand the above financial policy for Potomac Square Family Medicine Physical Therapy.

_____ _____

Printed Patient Name Printed Name of Guarantor (if applicable)

_____ _____

Signature of Patient (or Guarantor) Date