



Financial Policy/Assignment of Benefits/Release of Information

This agreement is between Muscatine Physical Therapy Services, P.C., as **creditor** and the **patient/guarantor** named on this form. By executing this agreement, you are agreeing to pay for all services/equipment that are received.

It is your responsibility to know the requirements of your insurance company. This includes participation, in network, out of network, referral requirements, second opinion, prior approval, precertification and outpatient and / or inpatients status. You are responsible for all co-payments, co-insurance and deductible required by your insurance plan. You must be aware of any pre-existing conditions, waivers or waiting periods, outlined by your insurance carrier.

Assignment of Benefits: I, the undersigned, agree that in consideration for the services rendered, do hereby assign payment to Muscatine Physical Therapy Services, P.C., of any monies received from the government agencies, insurance carriers, or others who are financially liable for my services.

Monthly Statements: If you have a balance on your account, you will receive a monthly statement. It will show your current balance and any charges still pending insurance. Unless Muscatine Physical Therapy Services, P.C., approve other arrangements in writing, **the balance in full on your account is due and payable within 60 days from the date of service.**

Insurance Claims: We will gladly submit your claims and will assist you in receiving the maximum benefit from your plan. All plans, however, have limitations and some may not cover 100% of the fees for our services. We will not bill to a third party payer, and example of this would be for a Motor Vehicle Accident or Personal Injury claim.

Co-Pay: Co-payments are due at the time of service. Your contract with your insurance company requires that you pay all applicable co-payments and deductibles. Failure to comply, could lead to loss of insurance coverage.

Co-Insurance/Deductible: Co-insurance/Deductible payments are estimated by the following sliding scale and are due at the time of services. If for any reason there is an overpayment on your account, once all insurance has been processed, you will receive a full refund of this amount within 60 days of final remittance from your insurance provider.

Co-Insurance	10%	15%	20%	25%	30%	35%
Estimate due at each visit	\$15.00	\$20.00	\$25.00	\$30.00	\$35.00	\$40.00
Deductible**	\$500.00	\$1000.00	\$1500.00	\$2000.00	\$2500.00	\$2501.00+
Estimate due at each visit	\$15.00	\$25.00	\$35.00	\$45.00	\$55.00	\$65.00

**At the time of your first visit if your deductible has not been paid you are responsible to make installments per visit, until you advise us that your deductible has been met and is confirmed.

Maximum combined Co-Insurance/Deductible estimate due at each visit is \$65.00

Divorce: In the case of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, **it is the authorizing parent's responsibility to collect from the other parent.**

Workers Compensation: We require written approval or authorization by your employer and/or Worker's Compensation carrier PRIOR to your initial visit. If your claim is denied, you are responsible for payment in full.

Uninsured Payment Options: Payment is required in full from the date of service, unless other arrangements have been made, in writing, with Muscatine Physical Therapy Services, P.C. A cash based program is available for those paying account balance in full on the date of service.

Extensive Treatment and/or Large Balances: We understand that medical bills can add up quickly and you may not be able to pay the balance in full within 60 days. We would suggest securing a bank loan for balances over \$1000.00, as we are unable to extend credit for long periods of time.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt by means of a collection agency or an attorney.

MONTHLY PAYMENT SCHEDULE FOR PATIENT BALANCE

\$0 - \$100	Payment in Full
\$101 - \$400	2 equal monthly payments
\$401 - \$700	4 equal monthly payments
\$701 - \$1000	6 equal monthly payments

We understand there will be some exceptions to these policies and are willing to work with you whenever possible.

Release of Information: Signing this form also allows Muscatine Physical Therapy Services, P.C., to release all physical therapy records needed to substantiate payment from any party that might be financially liable for this service. Physical therapy records may also be released to your physician, lawyer, and/or worker's compensation/employer as allowed under the HIPAA of 1996. This form does not or will not give permission to release or obtain information relating to substance abuse, mental health, and/or AIDS. If this information is required another written authorization will be acquired and signed. This is in accordance with Chapter 228 of the Iowa Code and section 141.23(3) of the Iowa Code and other applicable Laws.

Notice of Privacy: I have been informed and offered a copy of the Notice of Privacy Practices. By initialing this, I acknowledge I have been offered a copy of the Notice of Privacy Practices. _____(Initials)

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and this agreement will be in full force and effect.

Patient's Name: _____

Patient's Signature _____ **Date:** _____

Patient's Social Security # _____

Responsibly Party IF NOT THE PATIENT (such as a minor's account)

Name: _____ **Relationship:** _____

Signature: _____ **Date:** _____

Social Security # of Responsibly Party: _____