Garden Ridge Physical Therapy Financial Policy

Garden Ridge Physical Therapy is committed to providing you quality rehabilitative healthcare services. We support our staff and stand behind all the therapy programs developed for our patients. The patient-therapist relationship must be based on open and honest communication. Therefore, we request you read through the following policy and understand the financial responsibilities. The information is being presented to you in order to clarify our expectations and prevent any possible misunderstandings concerning the status of your account. If you have ANY questions, concerns, or comments regarding this policy, please bring it to the attention of one of our staff members and we will do our best to resolve the issue.

Medicare & Medicare Managed Insurance

As of January 1st of each calendar year there is a **maximum annual benefit of $1,870 per beneficiary**. This beneficiary cap is figured on both physical therapy and speech therapy combined (Occupational therapy is calculated separately). There are 90 exceptions to the cap which you may qualify for. Please ask your physical therapist if you qualify. We will do our best to maintain a running account balance and will notify the patient when the balance approaches the maximum allowable. To avoid any misunderstandings we suggest patients take an active role in the billing process to ensure that account balance does not exceed the cap. It will be the patient's decision to continue therapy beyond what is covered by Medicare. Ultimately, patients will be responsible for knowing their account balance as well as any amounts exceeding the maximum coverage allowable by Medicare. Patients will also be financially responsible for any annual deductible and/or applicable co-insurance according to their Medicare contracts. The number of sessions you receive could vary depending upon the type and cost of therapy. **Please inform us if you have previously received physical therapy at any other facilities.**

Medical Insurance Coverage

Billing insurance is done as a courtesy to the patient and does not dismiss the patient's responsibility for payment in full. Some companies will pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is the patient's responsibility to pay any deductible, co-payment, co-insurance, or any other balance not paid for by your insurance company. To avoid any misunderstandings we suggest patients take an active role in the billing process and inform themselves through their insurance company to ensure that they are aware of any deductibles, co-payments, and co-insurance. If a patient has secondary co-insurance coverage, it is their responsibility to make this known to our clinic. Failing to inform us of secondary insurance coverage will result in the patient being billed for any services not covered by their primary insurance carrier. Furthermore, if a patient has more than one insurance carrier, it is their responsibility to know which one is primary. By signing below, the patient recognizes, understands, and accepts that they are responsible for any and all charges for services rendered including, but not limited to, any services or fees not covered or denied by their insurance company.

Guarantee of Account

Please understand that payment for services is *part of your treatment.* Any payments for services not collected within 90 days from the service date may be may be turned over to a collection agency. Our facility will make every attempt to contact you for payment on your account before that step is taken. However, if we are required to turn your account over to a credit bureau or collection agency, your privacy rights will be forfeited and your account will be part of public record. By signing below the patient agrees to pay all charges associated with the cost of collection if their account becomes delinquent, including reasonable attorney's fees, court costs, finance charges, and the maximum legal rate of interest on the account until paid in full.

I permit a copy of this authorization to be used in place of the original. I authorize Garden Ridge Physical Therapy and Wellness Center to act as my agent in helping me obtain payment from my insurance companies. I authorize Garden Ridge Physical Therapy and Wellness Center to use photographs for use in documentation in my medical records if necessary.

Signature: ___________________________________ Date: _____________________