Financial Policy

Our goal is to get you better as quickly and cost-effectively as we can!

Therapy Charges:

Charges for therapy are not billed as "visits" like a doctor's office.

- Most charges are billed in 8-15-minute units based upon specific treatment types performed by your therapist
- It is difficult to know ahead of time exactly what treatment codes your therapist will perform as they adjust with each visit based upon your improvement and tolerance.
- An average estimated cost for a one-hour visit is $150.00.

Your Insurance:

Please keep in mind you are responsible for knowing and understanding your benefits, prior authorization requirements, and paying the balance of your account.

- We are happy to assist you by verifying your primary insurance benefits.
- We do not normally verify your secondary insurance.
- We will not be responsible for incorrect information passed on to us by you or your insurance carrier.
- We will file claims for payment with your primary and secondary insurances.
- **We do not file third party liability claims.**

Injury Related To: ☐ Employment ☐ Automobile accident ☐ Other 3rd Party Liability ☐ Not Applicable

You are responsible for payments at each visit in the amount of:

Deductible	$
Co-insurance	%
Flat Rate Copay	$
Private Pay	$

Estimated Payment Schedule	$
	$
	$
	$

Notice Disclosure Statement for out-of-network patients: **Yes:** ☐ **Not Applicable:** ☐

We are out-of-network (non-participating) with your insurance. You have a choice to be seen by a local participating provider. By choosing us, you acknowledge you will be liable for a higher out-of-pocket cost/balance bill.

Initials: ______________

WE OFFER INTEREST FREE DEFERRED PAYMENT PLANS AS WELL AS FINANCIAL ASSISTANCE.

My signature acknowledges I am responsible for understanding my insurance plan and any out-of-pocket financial obligations. I acknowledge that I am ultimately responsible for ensuring my insurance pays as it should, and am obligated to pay any remaining balance within 60 days of invoice (unless I have opted to participate in the deferred payment plan). I am responsible for notifying your office of any insurance changes.

Assignment of Insurance Benefits: I authorize my insurance company to make payment directly to this facility for services rendered to me.

______________________________ ______________________

Signature of Patient/Parent or Legal Guardian **Date**

______________________________ ______________________

Printed name of Patient/Parent or Legal Guardian **Staff Initials**

Get Better Faster…..Stay Better Longer!

Alamogordo Physical Therapy & Wellness Center, Inc.

Payment Plan

Your payments: We accept cash, checks, credit cards, and debit cards.

- If you have a **deductible** of less than $150, we will collect the full amount on your first visit.

- If your deductible is greater than $150, we will collect a minimum of $150 each visit to apply to your charges for that day. We will bill you or refund you for any balance remaining when your final claim has been processed.

- If you have a "percentage" **co-insurance**, we will estimate your percentage due based upon an average cost of $150 per hour long visit and collect that estimated amount each visit. Any balance will be billed or refunded upon receipt of your final insurance payment after discharge.

- If you have a flat rate **copay**, we will collect that amount at each visit.

- **No insurance:** If we are not filing any insurance claims for you, we will collect $100.00 each visit as payment in full for that visit. Please refer to the Good Faith Estimate.

Payment Plans:
Our mission is to get you back to your normal activities as quickly as possible in the least amount of visits/lowest possible cost. An important part of that mission is making the cost of exceptional care easy and manageable for our patients by offering several payment options.

If you are interested in a payment plan please let us know. We are happy to help.