

# 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!*

Carlsbad Physical Therapy & Wellness Center, Inc.

## Payment Plan

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**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.**