



Financial Agreement

Thank you for trusting Loudoun Physical Therapy to partner in your health care. This financial agreement should answer questions regarding patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have, and sign in the space provided. You will be given a copy of this agreement for your records.

I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection service. If it becomes necessary to send my account to a collection service, I agree to pay for all costs and expenses, including reasonable attorney fees. I also acknowledge that I have received a copy of this financial agreement for my records.

Patient Signature

Printed Name

Date

Parent/Guardian Signature

Printed Name

Date

Insurance

Your insurance coverage is a contract between you and your insurance company, and it is your responsibility to know your insurance benefits. As a courtesy, we will bill both your primary and secondary insurance companies. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, you will be billed and payment in full will be expected in 30 days of receipt of statement.



Medicare

We participate in Medicare program. You are responsible for your co-insurance, any deductibles that have not yet been met, and services that are identified as patient responsibility on your Medicare Explanation of Benefits. We strive to inform our Medicare patients of services that will not be covered. We may ask you to sign an Advanced Beneficiary Notice, which lists our fee and notifies you of your financial responsibility for certain medical services.

Managed Care

Many patients are enrolled in Managed Care Products. In order for us to obtain referrals and/or pre-authorizations for procedures, it is important that we have your current insurance information. Depending on individual policies, your procedure may not be a covered benefit. It is your responsibility to check for optimal coverage and policy limitations, and to obtain referrals as required by your insurance company. Please contact your insurance company with questions regarding your coverage.

Patient Responsibility for Payment

You are responsible for payment of any co-payment, co-insurance, deductible or service not covered by your insurance, handling, collection or attorney fees. If you do not have insurance, you are responsible for payment of all services. Co-payments are due at the time of your service. Patient due balances noted on your monthly statement are due within 30 days of receipt.

Payment Plans

We understand that financial circumstances vary from patient to patient. If you are unable to pay your patient due balance in full, you must call our business office at (703) 443-6700 to make payment arrangements.

Non-Payment

Failure to pay may result in your account being referred to a collection agency, which may affect your credit. In the event that any unpaid accounts are turned over to an attorney or collection agency for collection, I shall pay 100% of the attorney's fees; and interest on the unpaid principal balance; and all other legal fees and collection agency's cost pertaining to this encounter.