MEDICARE INFORMATION & AUTHORIZATION

PAYMENT POLICY:
Our commitment is to provide you with the best possible care. In order to do this, we need your assistance and understanding of our payment policy so that billing and collection costs are minimized.

MEDICARE:
We participate with Medicare and accept assignment. This means we will file with Medicare and they will make payment to us. You, the patient, are responsible for a specified amount, as determined by Medicare and indicated on the Medicare Explanation of Benefits that you will receive. This amount will be billed to you after Medicare has made payment. If it is determined that you are not covered by Medicare, you will be held responsible for the entire amount of the bill.

After your deductible is met, Medicare will **usually** pay 80% of approved charges and you will be responsible for the other 20%. You may have secondary coverage that will cover some of this: **all policies are different, so please check your policy if you plan to use this secondary coverage.** We will file your secondary claim for you if you provide us with this necessary information. Some secondary claims go directly from Medicare to the secondary payor, depending on whether the secondary payor has set that up with Medicare. **For patients without insurance, the initial evaluation is $155.00 and follow-up visits are $120.00** these amounts are determined based on average reimbursements.

CANCELLATION POLICY:
Please notify us **24 hours** in advance if you are unable to keep a scheduled appointment, otherwise the charge for the missed appointment will be **$50.00** (payable by you at your next visit). We have a recorder so you may call to leave a message at any time

*By your signature hereon, you agree to adhere to the above payment policy. Your failure to adhere to such payment policy does not in any way modify or waive the payment policy. In the event that **RESULTS PHYSICAL THERAPY Inc.** retains an attorney and/or collection agency any unpaid balance of your bill, then by your signature to this document you agree to pay all costs of collection including collection fees, attorney fees in the amount of 1/3 of the principal balance in default, court costs, and other reasonable and related costs.*

*By my signature below, I hereby authorize **RESULTS PHYSICAL THERAPY Inc.** to apply for benefits on my behalf for covered services rendered by same and request that payment be made directly to **RESULTS PHYSCIAL THERAPY Inc.** I certify that the information I have reported with regard to insurance coverage is correct. I further authorize the release of any necessary information including medical information for this or any related claim. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me in writing at any time.*
I HAVE READ AND UNDERSTAND THE FOREGOING STATEMENTS

SIGNED_____ **DATE**_____

PRINT PATIENT's Name: _____