



FINANCIAL POLICY

Insurance claims are filed as a courtesy to our patients. I, _____ authorized my insurance company to make payments directly to Allen Therapies, Inc. for services rendered to me or insured dependant.

Are you receiving any health related services other than outpatient physical therapy? Yes or No
(Home health agency nurse or aide)

Have you received any out patient physical therapy during the current calendar year? Yes or No
If yes, with which clinic? _____

Private Pay: If you have no insurance coverage, payment in full is due at time of service. Our policy is designed to give you a number of payment options. You may use cash, check, MasterCard, Visa, Discover and American Express.

Commercial: Coinsurance, Co-Pays and deductible amounts are due at the time of service. If your insurance plan requires prior authorization, our office will obtain it prior to your appointment. You are responsible for the balance of your account after 45 days.

Medicare: Our office will bill all covered services directly to Medicare. If you have Medigap (secondary or supplemental) coverage, it will be billed for you. Allen Therapies, Inc. agrees to accept the Medicare allowable amount as the full charge.

Medicaid: All covered services will be billed by our office directly to MEDICAID. If payment denies for reasons of expired eligibility, payment in full will be due immediately. A current MEDICAID Card and appropriate prior authorization from your primary care physician are due at your appointment time.

Worker's Comp: Verification of your work-related injury will be obtained prior to your appointment. Claims are filed directly with your employer's insurance carrier.

I hereby give written consent to evaluation and treatment by a licensed physical therapist employed by Allen Therapies, Inc. I understand and agree that regardless of my insurance status.

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or the provided information.

I am responsible for the deductible, co-insurance and non-covered services.

My signature below represents authorization to bill the insurance company for services rendered to me. I am ultimately responsible for the balance of my account for any professional services rendered.

My signature below authorizes Allen Therapies, Inc., to process any manual, over the phone or written credit card transaction for payment of services rendered.

_____/_____/_____
Signature of Patient or Guardian Date

_____/_____/_____
Allen Therapies, Inc. Representative Date