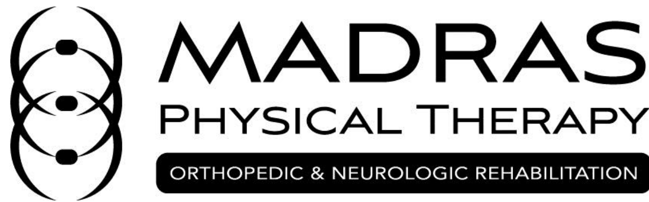

Thank you for allowing Madras Physical Therapy to assist you with your rehabilitation. In the interest of good health care practices, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end. Our goal is to make the financial aspect of your recovery as stress-free as possible.

As a courtesy to you, we will bill your insurance. **If there are any changes in your insurance, please let us know immediately so we can submit your claim properly**. We cannot accept responsibilty for collecting on an insurance claim after 60 days or for managing a disputed claim. Insurance reimbursement is a contract between you, your employer and your insurance carrier. **Co-pays are due at each visit.** You will begin receiving monthly statements with balances after your insurance company has been billed. If you have any questions about your charges or statement, please contact **Madras Physical Therapy at 541-475-2571.** The balance of the account is due upon reciept. There will be interest applied after ninety (90)days.

I, the undersigned:

- o have insurance coverage, and authorize direct payment from my insurance carrier to Madras Physical Therapy .   You are responsible for any charges, or portions of charges that your insurance does not pay.

  Note: You are responsible for knowing your coverage benefits. MPT will make every effort to inform you if a supply or service is not covered by your insurance.
- o do not have insurance and understand that I am responsible for payment of all charges. Current cash rate for treatment per 1 hour visit is **$100.00**

I have read this policy and understand that regardless of my insurance coverage or lack thereof, I am responsible for payment of my account. IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, I AGREE TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES. This will insure that our responsible patients will not be penalized to cover costs incurred by those who do not pay on time.

PRINT PATIENT NAME:____

PATIENT SIGNATURE:____DATE:________

PARENT/GUARDIAN must sign if patient is under 18 years of age

SIGNATURE:____DATE:________________