THERAFIT LLC

Physical Therapy/ Fitness

Billing Policy, Release, and Authorization

It is our policy to bill your insurance carrier, although you are responsible for the entire bill when services are rendered. **We require payment of your estimated share be paid at time of each visit**. If your insurance carrier does not remit payment within 90 days, the balance will be due in full from you. Please beware that you may also have an annual deductible that has to be met before insurance will begin reimbursing your claim.

I authorize TheraFit, LLC to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to TheraFit, LLC. I authorize TheraFit, LLC to release medical or other information necessary to process this claim. I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance or co-payment, as well as any charges not reimbursed by my insurance carrier. I understand, and/or have reimbursement limits on physical therapy treatment.

(**Initials**) _____ - **I understand I am responsible for knowing and meeting the requirements of my insurance plan.**

*__**Note**__: TheraFit, LLC will work with setting up an agreeable payment plan each month, with no interest, if you have difficulty making the full payment amount. However, if no payments are made after 3 months you will be turned over to a collection agency. You will be responsible for all costs for collecting monies owed, including court cost, collection agency fee up to 50% over cost and any attorney fees.

(**Initials**) _____ - There will be a **ONE TIME** fee for electrodes ($12.00) and therabands ($10.00) if used in the clinic. These items are **NOT** always covered by insurance. We will bill your insurance first, if they do not pay, then it will be patient responsibility. Any questions regarding this charge, please ask at the front desk, we will be glad to answer any concerns you may have.

(**Initials**) _____ - Starting February 1st, 2020, there will be a **__$50.00 Fee__** if you do not show for your appointment, or if you fail to cancel your appointment **by 6:30pm the previous business day**. You may bring a doctors note, ER paperwork, or an accident report for the No Show fee to be waived.

You may leave a voice-mail on weekends or holidays by **midnight** the day before your appointment

Signature: _____ Date: _____