proaxistherapy™
INNOVATIVE THERAPY RESOURCE

FINANCIAL POLICY FOR PROAXIS THERAPY

As a courtesy to our patients, we check the insurance coverage and benefits for therapy services; however, it is the patient's responsibility to verify coverage, understand their particular insurance and insure that payment is made.

Therapy services are billed on time based procedure codes. Your therapist will perform a variety of activities with you in order to maximize your recovery and help you to reach your goals. The therapist will choose the appropriate charge codes based on the activities that are performed and how much time is spent on each procedure or activity.

In the information below, we are <u>ESTIMATING</u> the amount of money you will need to pay after you insurance has been filed. The information below does not guarantee insurance coverage or insurance payment. When insurance benefits are verified, the insurance company does not guarantee payment. If the insurance company denies coverage, you will receive a bill for those services.

Proaxistherapy does not accept third party liability insurance. If you have been involved in an accident where there is third party coverage, you will be responsible for paying for therapy services rendered by proaxistherapy at the time that services are rendered and collecting from the third party.

The amount not covered by the primary insurance company is <u>estimated</u> below. That amount is payable on the date that services are rendered. This estimate is determined by benefits from your plan or from a predetermination from your insurance company. Please understand that this is only an estimate and that insurance companies have their own schedule of what they consider to be "usual and customary". These fees often vary between plans. Our charges are based solely on the amount of time, skill and care that is provided by your therapist for each individual treatment session. Therefore, it is not uncommon to find a difference in our charges and the insurance payment. If we are in network for your insurance carrier, you will be responsible for the insurance allowable. If we are not in network for your insurance, you will be responsible for the difference between the allowable and the charge. Please understand that your insurance is an agreement between you, your employer and the insurance carrier.
<u>PAYMENT IS DUE AT THE TIME THAT SERVICES ARE RENDERED</u>.

The information below is provided as a courtesy to you but is an <u>ESTIMATE</u> of your insurance benefits and does not guarantee insurance payment. If you have NOT met your deductible, we will take a deposit from you towards your deductible at each visit until you meet the deductible. You will receive a bill for the difference between the deposit and the insurance allowable after the insurance has communicated the allowable. If you have had a recent procedure that should apply to your deductible, it may not have been billed by the hospital or physician's office and therefore, may not be listed when we checked your benefits. If you have a co-insurance percentage that you are expected to pay, we will collect an estimated amount on that co-insurance and you will receive a bill for the difference between what you paid and what the insurance company allows. <u>We encourage you to contact your insurance company to better understand your benefit for therapy services.</u>

rWe **ARE** contracted with your insurance company
rYour individual deductible is $___________
rYou have met $____________ of your individual deductible
rYour family deductible is $___________
rYou have met $____________ of your family deductible
We require a payment of $_________ towards your deductible

r We are **NOT** contracted with you insurance company
r Your co-pay for each visit is $______
rYou are responsible for a co-insurance of _________ percent
rWe require a payment of $__________ towards that coins. per visit
rYour total out of pocket is $_________
rYou have met $____________ of your total out of pocket expenses

r Your insurance allows $_______for therapy each benefit year. We estimate that to be _________ visits. This does **<u>not</u>** guarantee this number of visits, but this is an estimate to assist you in making decisions regarding your therapy.
rYour benefits allow you _______ PT/OT visits each benefit year.
rYour insurance requires precertification and has authorized _______ visits. Pre-certification Expires on _________
rYour benefits are pending because: ____

I have read the information above and understand that I am responsible for payment of therapy services not covered by my insurance policy.

x____ ____

Patient / Guardian Signature **Date**