9 Durant Ave
Bethel, Ct 06801
P: (203) 826-9885 F: (203) 826-9888
Excelospt.com

FINANCIAL POLICY

We are committed to providing you with the best possible service and ask that you read and acknowledge the terms of our Financial Policy.

PAYMENT: All payments including copay, coinsurance and deductible are due on the date of service. As a courtesy to our patients, we will contact your insurance provider to verify your physical therapy coverage. We cannot, however, guarantee the accuracy of the information we receive from your insurance provider.

COINSURANCE/DEDUCTIBLE: If you have a plan with coinsurance percentage or deductible which has not been met, we will estimate the coinsurance/deductible amounts based on what we have been lead to expect from your insurance company. Please note that any payment made on the date of service is considered a DEPOSIT toward your ESTIMATED patient balance. Because this is an estimate, there is always the possibility that you may be either responsible for an additional balance or due a refund. If a refund is due – it will be promptly provided. If it turns out that your insurance company payment is less than expected – you are responsible to promptly pay any additional balance due. An unpaid balance over 30 days past due may be referred to a collection agency. *I have read and understand the above.
Please initial here: _____

INSURANCE: We encourage you to call your insurance company with any specific questions related to your policy's outpatient physical therapy benefits such as deductible, copayment, coinsurance, visit limitations i.e., sharing of outpatient benefits with acupuncture, chiropractic or occupational care, effective annual calendar renewal date, or any pre-authorization requirements. Excel PT cannot assume responsibility for incorrect information provided to us concerning your insurance policy. Our courtesy verification of eligibility and benefits does not guarantee that your insurance company will pay for all services provided. Your insurance policy is a contract between you and your insurance company. You are responsible for knowing your level of coverage and are ultimately responsible for the full payment of your bill.
Please initial here: _____

CANCELLATION POLICY: Therapist time is reserved for your appointment – if you are unable to keep your appointment, we kindly ask that you provide us with 24-hour advance notice of cancellation. If you fail to cancel a scheduled appointment 24 hours in advance, or "no-show" an appointment, we reserve the right to assess a $50.00 cancellation fee. I have read and understand the above Excel PT Financial Policy, I agree to the terms, and understand that I am ultimately responsible for payment of the health care services provided.
Please initial here: _____

Printed Patient Name:
_____

Printed Name of Guarantor (if applicable):
_____

Signature of Patient (or Guarantor): _____

Date: _____

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PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Excel Physical Therapy's Notice of Information Practices. I understand that Excel Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that if I notify the practice, I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations. I also understand that Excel Physical Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Excel Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name: _____

Signature: _____

Signature of Parent/Guardian (If patient is a minor): _____

Date: _____