



## MEDICAL ASSIGNMENT OF BENEFITS & FINANCIAL POLICY

The team at Spooner Physical Therapy is pleased to be a part of your rehabilitation experience, and we thank you for choosing us. We find that communication with our patients regarding our financial policy assists in providing the best service to you.

### INSURANCE BILLING

We will gladly call your insurance company to identify your current benefit coverage. However, please understand that **insurance companies will not guarantee medical benefits over the phone.** We can only use this information as an estimated guideline. Actual determination is made 4 to 8 weeks later after we receive the written notification and/or payments on your claim. We strongly encourage you to contact your insurance company directly in order to understand your plan's coverage and limitations. Please note that we will only bill up to two (2) insurance companies (primary & secondary) for MEDICARE related claims & only one (1) insurance company (primary) for all other claims, unless prior arrangements have been made with our Business Center.

Your insurance company may also require a current therapy prescription (prescriptions expire 30 days from the date they are written), a "Letter of Medical Necessity" written by your physician and/or pre-authorization directly from your physician for therapy services. This is your responsibility to obtain and non-compliance with this may result in services not being reimbursed by your insurance company.

### PAYMENTS

**All deductibles, co-pays, co-insurance and cash pay estimated amounts are due at the time of service, unless other written arrangements have been made with our facility.**

Once we have received all payments or notifications from your insurance company, we will present you with your final statement. Payment for any outstanding balance will be due in full no later than 30 days from the date of your final statement. If we do not receive the payment-in-full 30 days from the date of your final statement, we may be forced to pursue legal collection proceedings and you will be responsible for an additional 35% collection fee. Please do not hesitate to ask us any questions or request a copy of your account balance.

Again we appreciate your choosing Spooner Physical Therapy.

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By signing this form, I the patient (or legal guardian of the patient), have read, understood and agree that I am 100% responsible for all fees incurred here at Spooner Physical Therapy. I agree to authorize Spooner Physical Therapy to release my medical information to insurance companies, physicians, attorneys and to all other pertinent parties that may be involved in my claim or care. I also agree to assign all payment of benefits to Spooner Physical Therapy.

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Patient Name (Please print)

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Patient Signature (or Legal Guardian)

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Date