

PAYMENT POLICY

Thank you for choosing Berube Physical Therapy, Inc. We are committed to providing you with the best possible service and ask that you please read and acknowledge the terms of our financial policy.

PAYMENT: All payment, including copay, coinsurance, and deductible are due on the day of service. We accept cash, checks, Visa, Mastercard, American Express, Discover, and CareCredit® cards. 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.

COPAY/COINSURANCE/DEDUCTIBLE: If you have a copay (a set amount per visit), payment is expected at the time of service. If you have a plan with a coinsurance percentage or deductible which has not been met, we will estimate the coinsurance/deductible amounts based on what we have been led to expect your insurance company will pay. Please note that any payments made on the date of service is considered a **deposit** towards your **estimated** patient balance. Because this is an estimate, there is always the possibility that you may be either responsible for an additional amount or due a refund. If a refund is due, it will be promptly provided. If it turns out that your payments are less than your actual responsibility *per your insurance carrier*, you are responsible to remit any balance due. **An unpaid balance over 30 days past due may be referred to a collections agency.**

INSURANCE: We are happy to help in contacting your insurance company; however, **this is a courtesy** and **does not** guarantee benefit levels, reimbursement, deductibles, copay amounts, coinsurance, visit limitations, preauthorization requirements, or other information. **Berube Physical Therapy, Inc, 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 will pay for all services provided. Your insurance policy is a contract between you and the carrier. **You are responsible for knowing your level of coverage for physical therapy in an office setting and are ultimately responsible for the full payment of your bill.**

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 \$40.00 cancellation fee.**

PLEASE SIGN AGAIN TO ACKNOWLEDGE YOU HAVE FULLY READ AND UNDERSTAND OUR PAYMENT POLICY

I have read and understand the above Berube Physical Therapy, Inc, financial policy. I agree to the terms, and understand that I am ultimately responsible for payment of the health care services provided.

I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 40% of the balance, including attorney/court costs, will be added to the balance of my account.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____