Terri Anderson LMT, CIMI

(503) 348-4794

FINANCIAL POLICY

We have established the following financial plan regarding our credit policies. Although we cannot address every possible circumstance, here are the basics. If you have any questions regarding any of these policies, please do not hesitate to discuss them with the therapist or our Business Office Manager.

1. Services for Non-Insured patient's: Full payment is due at time of service.
2. As a courtesy, we will bill primary and secondary insurance; however, you are responsible for the payment of your balance upon
   receipt of your statement.
3. Co-pays are due at time of service. If they are not paid, there will be a $10.00 fee assessed in addition to the missed co-pay. The missed co-pay and additional fee MUST be paid prior to your next treatment.
4. Non-sufficient funds (NSF) fee of $30.00 will be assessed for any returned checks plus the amount of the returned check. This also MUST be paid prior to your next treatment.
5. If the patient is a minor, the person who has signed this financial policy is responsible for the payment of the charges.

MOTOR VEHICLE ACCIDENT (MVA)

If you are receiving treatment due to a MVA, you are responsible for paying all charges assessed during your course of treatment that are not reimbursed by the Personal Injury Protection (PIP) coverage. If your motor vehicle accident claim is in dispute, we will bill your regular medical insurance carrier. If you do not have medical coverage, you will be responsible for all charges related to your treatment.

WORKERS COMPENSATION (W/C)

We will bill your workers compensation carrier for all treatment related to your accepted condition. If your workers compensation carrier denies the claim for any reason, including not being related to the accepted condition, we will bill your private insurance. All costs not covered by the private insurance will become your responsibility. If you do not have private insurance you will be responsible for the assessed charges.

CANCELING AN APPOINTMENT

It is our policy that we require a one (1) business day or 24-hour notice prior to the appointment you are canceling. There is a $30.00 no show fee if appointment is not cancelled in person or by phone within this time frame. Special circumstances will be reviewed individually.

FINANCIAL AGREEMENT

By signing below, you are acknowledging and agreeing to all the above stated policies and are assuming full financial responsibility for all charges.

AUTHORIZATION TO RELEASE INFORMATION ASSIGMENT OF INSURANCE BENEFITS

I agree to allow medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan**.** This authorization will remain in effect until I have requested in writing for it to be revoked. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize to release all information needed to secure the payment.

I have read and understand the above financial and release of information policies.

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Patient's signature (Parent or Guardian if a minor) Print Name Date

Updated: 06/04/10 TA/JMB