# CLINIC FINANCIAL POLICY

1. Payment is expected at the time services are rendered. (Checks, Cash, Credit Cards).

2. If cancellation of appointment is made less than 24 hours prior to the scheduled appointment, a $70.00 fee will be charged. This fee is due upon the next visit and can not be billed to insurance. If you arrive more than 20 minutes late, there will be a $70 fee for your appointment time. Your physical therapist will use the remaining time as best possible.

3. If S.T.A.R. is a participating provider with your insurance company, your insurance coverage must be pre-verified by S.T.A.R. for us to submit your bill to your insurance carrier. Otherwise, you are responsible for full payment at the time of the office visit. If any procedure or visit is denied by your insurance the patient is responsible for payment in full.

4. It is the patients' responsibility to know the requirements of their insurance carrier to cover physical therapy services. The referral and/or prescription for physical therapy services must be current (within 30 days of beginning physical therapy). If your plan requires referral from a primary care physician for physical therapy services, you are responsible for knowing this requirement of your plan. It is also the responsibility of the patient to monitor the number of authorized visits for physical therapy. Frequently, an insurance carrier will reject payment if the referral is not current or authorized visits have been exceeded.

5. Patients are responsible for payment of services if they have not met the requirements of their insurance carrier for reimbursement. There may be charges that your carrier will not pay per your insurance policy. You will be responsible for payment of all charges for physical therapy services provided. Your physical therapist will plan your treatment based on the best techniques judged to expedite your recovery.

6. PPO/HMO plan participants are responsible for their designated Co-Pay at each visit. Individuals are personally responsible for full payment of rehabilitation supplies, anti-inflammatory medications, braces, and custom orthotics.

7. S.T.A.R. clinic is a participating provider with Medicare. Therefore, patients pay any applicable deductible and/ or co-insurance at the time of the visit. Please request the information sheet about Medicare from the receptionist. Any supplies given will not be paid by Medicare. We are not a supplier of medical supplies and equipment for Medicare.

**PLEASE TURN PAGE FOR ADDITIONAL POLICY, SIGNATURE AND INSURANCE**

8. If special Summary Reports, Insurance Reviews, or other reports are requested, a $95.00 minimum fee must be paid in advance. Extensive legal/medical reports will require a $150.00 prepayment. These fees do not apply to standard communication and progress reports to physicians.

9. Workers Compensation cases will be billed directly to the insurance carrier. However, if reimbursement is not received within sixty (60) days, the S.T.A.R. Clinic reserves the right to terminate treatment and direct the patient to another treatment facility.

10. Auto insurance payments must be from the patient's own auto carrier and not another auto carrier. Payment from the patients' carrier must be made in full within thirty days after submitting. S.T.A.R. does not wait for payment after legal settlement. We do not accept your carrier's UCR charge as payment in full. The balance of payment will be the responsibility of the patient.

11. I agree to reimburse Sports Therapy And Rehabilitation, Inc. for any expenses, including attorney and collection fees, incurred in connection with the collection of sums due for services rendered.

INSURANCE COMPANY _____

POLICY HOLDERS NAME _____ RELATIONSHIP (If not self) _____

POLICY NUMBER _____ GROUP NUMBER _____

CONTACT PHONE NUMBER _____

**I understand the above S.T.A.R. Clinic Financial Policy and agree to be responsible for payment of the listed charges.**

- **Practice brochure received _____**
- **Notice of Privacy Practices received _____**

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**(Patient Signature/ Date)**