Loudoun Sports Therapy Center

"Don't let pain limit you. We Care. We Listen. We Get RESULTS!"

FINANCIAL POLICY

At Loudoun Sports Therapy Center, our patients' care is our primary concern. **In order to avoid any miscommunication, we would like you to review the following financial policy**. We encourage you to come to us without hesitation regarding any questions or concerns you may have. **Please read each part of this agreement and initial on each of the provided lines**:

_____As a courtesy to you, we will verify your insurance benefits and eligibility prior to your evaluation. At initial visit, we will inform you of the benefits information we have received from your insurance company and provide you with a written copy of your benefits. Please be aware, it is your responsibility to verify your own insurance benefits information. We will assume no responsibility for errors made by your insurance carrier and assuring payment is ultimately your responsibility.

_____If your insurance company requests further information **from you**, it is **your responsibility** to complete the request immediately. If you do not complete their request and they deny payment, you are responsible for the billed amount for all denied services.

_____If your insurance company denies payment for services because you are beyond your yearly max visits or allowed amount or for not meeting medical necessity, you will be fully responsible for payment for services rendered.

_____**If your address, phone, or insurance change during your care, it is your responsibility to immediately inform Loudoun Sports Therapy Center staff. If you fail to inform us of changes, you will be responsible for the full cost of any denied claims or late fees.**

_____**Payment is expected at the time of service**. Failure to do so could result in a late payment fee for which you are responsible.

_____**With the exception of Medicare, we do not accept assignment from secondary insurances.** In the event that you have a secondary insurance we would be happy to file the necessary claim forms for your secondary insurance however any payment not made by your secondary insurance will be your responsibility. For all Medicare patients, the secondary claim is submitted automatically on your behalf.

_____If your address changes during care or before you have completed payment on your account it is imperative that you notify us immediately of any changes. This will help you avoid late payment charges and potential court fees.

_____**If you do not have health insurance or wish to pay privately for your care, please speak with our billing representative today. We will work with you to set up a payment plan.**

_____**We do not wait for lawsuits to settle for payment**. If you are involved in a lawsuit related to your injury, we expect payment at the time of services. We will gladly assist you in setting up a payment plan but full payment is expected and is your responsibility.

_____There is a $25-$50 charge for returned checks depending upon bank fees.

_____If your account becomes inactive (meaning you have not made a payment for 30 days or more), we will add a non-negotiable $25 late fee to your account.

_____If your account remains inactive for 60 days, we will apply an additional $50 late fee to your account.

_____If your account remains unpaid, either in part or in full, for 90 or more days you will receive a subpoena demanding your appearance in small claims court or we will send your account to collections. There is an additional $125 fee for these costs. These costs will be applied to your account and will be your responsibility.

_____**As a courtesy to you, we will set up payment plans if needed**. Please ask to speak to our Billing Representative to set up a payment plan on your account to allow you to pay for your care over a longer period of time. If you have not set up a payment plan then payment is due at the time of treatment. Payment plans do not decrease the amount owed for your care – just allow you to pay over time.

By signing below, I acknowledge that I have read and understand Loudoun Sports Therapy Center's financial policy and I agree to the terms there above. I understand that medical insurance claims will be filed on my behalf and by signing below I agree to such billing. I authorize my insurance company to remit payment for therapy services to Loudoun Sports Therapy Center at the address listed on the claims. I also authorize the release to my insurance company any medical information necessary to process my claims for payment. **I understand that if my insurance company denies payment for any reason, I am responsible for payment for services rendered at Loudoun Sports Therapy Center**. I accept all terms of this agreement.

_____	_____	_____
Patient Signature (Parent/guardian if pt under 18)	Patient Name (printed)	Date
_____	_____	
Parent/Guardian Name (printed)	Witness	

12.24.2019