Pritchette Physical Therapy

orthopedic & sports rehabilitation

aquatic therapy • sports performance

CLINIC AND PATIENT RESPONSIBILITIES & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

IT IS THE PATIENT RESPONSIBILITY:

- Patients need to know and understand their insurance policy/policies. Patients should be aware of benefit coverage including which healthcare providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, co-insurance and co-payments. If you are not familiar with your plan coverage, we recommend that you contact your carrier directly.
- To obtain a referral from their Primary Care Physician (PCP) and/or obtain authorization for treatment from their insurance carrier prior to receiving services. Any non-covered services are the financial Responsibility of the patient.
- To pay the co-payment, deductibles, and coinsurance at the time of service.
- To notify Pritchette Physical Therapy of cancellations as soon as possible. If a cancellation is received less than 24 hours or you are a no show for a scheduled visit, Pritchette Physical Therapy reserves the right to charge you $25.00 for these types of cancellations and/or no show.

IT IS PRITCHETTE PHYSICAL THERAPY RESPONSIBILITY:

- To provide quality medical care.
- To file insurance claims for our patients. Claims are filed with insurance carriers no less than 3x/week.
- To send patient statements periodically during treatment and balance is due upon receipt of statements.

FINANCIAL POLICY ACKNOWLEDGEMENT AND ASSIGNMENT OF BENEFITS:

I have read and understand the above financial policy. I understand that, regardless of my insurance claim status or absence of insurance coverage, I am ultimately responsible for the balance on my account for any services that were rendered. If I receive insurance payments directly from my insurance, I will immediately sign over the check to Pritchette Physical Therapy.

My signature acknowledges receipt of HIPAA compliant Notice of Privacy Practices. I will receive a copy only when I request one.

Patient or Responsible Party Signature DATE

Printed Patient Name

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