Policy and Procedures

Initial Please:

X_____ As the patient/guarantor, you are financially responsible for any fees and costs associated with any services you receive from our business. This includes physical therapy evaluation and treatment. Payment in full will be collected at the time of service. Services fees are not refundable.

X_____ There will be a $30 fee for returned checks.

X_____ Peregrine Physical Therapy is an **out of network provider**; meaning that we do not contract or participate with insurance companies. Patients are responsible for payment of the entire cost of the visit upon conclusion of the appointment. Patients will be provided with a copy of their bill at the end of the month following treatment so they can submit the bill to their insurance company if they so choose.

X_____ We are a **non-participating Medicare provider**; meaning that payment is required to be made directly to the therapist and the company will send a bill on a monthly basis to Medicare for patient reimbursement. Medicare may reimburse the patient up to 80% of the charged fees.

X_____ We charge for copies of medical records when requested from patients, insurance companies, and other doctor's offices. The patient is responsible for all copy charges. Copy charges are $25.00 for small records and $50.00 for large records.

X_____ Cancellation Policy: If an appointment cannot be kept, or less than 24 hours notice is given, the patient is responsible for the entire cost of the visit.

X_____ If a patient misses 3 appointments, Peregrine Physical Therapy reserves the right to cancel all future appointments.

Patient Responsibility

I understand and agree that I am financially responsible for all charges for any and all services rendered.

I understand that while my insurance may confirm out of network benefits, confirmation of benefits is not a guarantee of reimbursement and that I am financially responsible for services rendered.

I understand and agree that it is my responsibility to know if my insurance has any deductible, copayment, coinsurance, out of network, usual/customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral, my insurance will not reimburse me for any services and that I will be financially responsible for all services rendered.

I agree to inform the office of any changes in my insurance coverage.

Printed Patient Name (and Guardian Name if applicable)_____

Patient or Guardian Signature_____ Date:_____