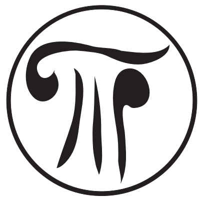

Pillars Physical Therapy
and Wellness Center

2nd Floor, Suite D, 307 87th St.,
87th Street Plaza Daly City, CA 94015
Tel: (650) 550-0050 • Fax: (650) 550-0070
www.pillarspt.com

FINANCIAL POLICY & AGREEMENT

I understand and agree that:

- It is my own responsibility to understand my insurance coverage as it relates to the service I am about to receive. Some insurance companies may require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatment. I am responsible for knowing and meeting the requirements of my insurance plan.

- Pillars Physical Therapy & Wellness Center will verify my physical therapy coverage with my insurance carrier(s) prior to initiating any treatment on me. However, depending on my insurance plan, there is no guarantee that the actual payment that will be made by my insurance carrier(s) will be the same as what was previously verified.

- It is my insurance carrier(s) who decides what to reimburse Pillars Physical Therapy & Wellness Center only after the bills are reviewed and processed. Pillars Physical Therapy & Wellness Center has no authority or ability to decide what treatments will/will not be paid or reimbursed.

- I am responsible for the financial obligation arising from the physical therapy services I am about to receive. I agree to pay my deductible, my co-insurance, or co-payment when due, and any charges not reimbursed in a timely manner by my insurance carrier.

- Pillars Physical Therapy & Wellness Center will bill my insurance carrier directly for the charges on my treatment and I authorize/assign payment of my medical benefits directly to Pillars Physical Therapy & Wellness Center.

- Depending on my insurance plan, the ‘out-of-pocket’ fees may come out cheaper than insurance deductibles, co-insurance, and co-payments combined. Once I have authorized Pillars Physical Therapy & Wellness Center to bill my insurance carrier, I will not be able to revert to the ‘out-of-pocket’ pre-payment or per service discounted rates.

- If my insurance policy has a deductible larger than $100.00 and the insurance company says it has not been met, then I will need to pay Pillars Physical Therapy & Wellness Center $100.00 at my first visit before any services are rendered to me; and $100.00 on each succeeding visits until my deductible limit has been met. If at the end I have made an overpayment, Pillars Physical Therapy & Wellness Center will reimburse me as soon as my insurance carrier has fully processed the claim.

- If I have a co-insurance of 30% or more, Pillars Physical Therapy & Wellness Center will collect $45.00 prior to each service. This amount is only a portion of my balance and that my actual financial responsibility can only be determined once my insurance carrier has fully processed the claim.

- It is my responsibility to notify Pillars Physical Therapy & Wellness Center of the current addresses and telephone numbers of my insurance carrier(s) and any changes in my insurance that occur while I am already undergoing treatment in the clinic.

I understand and agree that:

- Pillars Physical Therapy & Wellness Center does not accept any attorney, third party, or personal injury liens.
- Credit cards: Pillars Physical Therapy & Wellness Center accepts Visa and Mastercard only. However, a minimum bill of $15 is required prior to the use of these credit cards.
- Returned checks: Issuers of returned checks will be charged a fee of $30 per check.
- I am fully aware that any unpaid balances will be charged 15% interest per month which will be compounded until fully paid.
- If it is necessary for Pillars Physical Therapy & Wellness Center to employ a collection agency and/or attorney to enforce or to collect from me my unpaid balances based on this agreement, I will be responsible for the payment of all fees incurred, including interest, court costs, collection agency commissions or charges, and attorney's fees.

MEDICARE PATIENTS

- If I do not have supplemental insurance, I will be responsible to pay for the 20% co-insurance portion normally not paid by Medicare. I am also responsible for any of my deductible.
- If I have supplemental insurance and my supplemental insurance carrier, for any reason, will not pay the 20% co-insurance, then I am responsible for the payment of the said 20% co-insurance.

I have read, understood and accepted the terms of this agreement. I am the patient, or the party authorized by the patient, (as guardian or general agent), to execute this agreement.

______________________	______________________	__________
Patient's Printed Name	**Patient's Signature**	**Date**
______________________	______________________	__________
Guardian's/General Agent's Printed Name	**Guardian's/General Agent's Signature**	**Date**