ALPINE PHYSICAL THERAPY

NO INSURANCE/CASH RATE: We believe that no one should be denied physical therapy services secondary to lack of insurance coverage. Our clinic offers a discounted cash rate to those who do not have appropriate insurance coverage. Payment will be required at the time of service unless arrangements are made in advance. Please inquire about our current cash pay rate if it is applicable to your situation.

RETURNED CHECKS: A **$30 NSF (non-sufficient funds) fee** will be charged for any checks returned to our office because of insufficient funds. If we receive a returned check, we will notify the patient or responsible party immediately and request that a cash payment be brought to one of our locations within 24 hours to replace the full amount of the check.

FINANCIAL ASSISTANCE PROGRAM: We have a payment assistance program for qualifying families with limited incomes and/or extenuating circumstances. To determine whether your family qualifies for this program please call and request an application. All requests for the assistance program will require the following information:

Completed application form
Copy of your last income tax form
All applicable W-2 forms
Two most recent pay stubs from each employed adult in the family
A copy of the check stub from the unemployment office, if applicable.

COLLECTIONS: If your account is **more than 90 days past due**, without an established payment plan on file, we will begin immediate collection actions. We will begin assessing your account a **3% finance charge**, based on your remaining balance, unless you have a payment plan in place. If you do not pay your bill following our internal collection efforts, your account will be sent to an **outside collection agency**. If your account is sent to a collection agency, you will need to contact them directly to settle your balances.

REFUNDS: A refund is issued when an overpayment has been identified, if you feel a refund is due, please contact our billing office at 801-216-4298.

AUTHORIZATION FOR TREATMENT & FINANCIAL AGREEMENT

I authorize the treatment of the patient named below and agree to pay all fees and charges for such treatment. Charges shown on statements are considered to be correct unless notification is received within 30 days of the statement date. I agree to pay all charges within 30 days of the statement date unless prior arrangements have been made with the billing office. I agree to assign my insurance benefits to Alpine Physical Therapy if applicable.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize Alpine Physical Therapy to release my health care information or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

I authorize my healthcare providers to release personal health information as it pertains to my rehabilitative care if any is requested by Alpine Physical Therapy.

AUTHORIZATION TO FILE CLAIM

Should my insurance company fail to comply with state laws and timely filing limits, I authorized Alpine Physical Therapy to contact the state insurance commissioner to file a claim on my behalf. By filing a claim, we can assist the state in identifying problematic situations and companies with a propensity for delaying or selectively reducing claim payment.

I have read and agree with the above information.

Patent Name: _____

_____ _____

Signature of Responsible Party (must be over 18 years old) Date