PAYMENT POLICY / PERMISSION SHEET

This document authorizes: PAULA DILLON MAYS PHYSICAL THERPAY CLINICS:
SOUTH HILL PHYSICAL THERAPY
AIRWAY HEIGHTS PHYSICAL THERAPY
VALLEY PHYSICAL THERAPY
PHYSICAL THERAPY NORTH
AND/OR DIVISION STREET PHYSICAL THERAPY

To share information about my case with my doctor, attorney or insurance company as stated on the Notice of Privacy Practices.

TREATMENT TIME: The Initial Evaluation is approximately 60 minutes. Regular visits will average 45 to 60 minutes per treatment, depending on your condition.

SCHEDULING: We will attempt to schedule your appointments to accommodate your schedule. Please let us know a day ahead if it is necessary to cancel your appointment. There will be a $25.00 cancellation fee if you cancel you appointment without giving a 24 hour notice.

BILLING: out office will bill your insurance for physical therapy services. **ALL CHARGES NOT COVERED BY INSURANCE ARE THE RESPONSIBILITY OF THE PATIENT**. All charges for supplies are due when the item is dispensed to the patient, except when prior approval is obtained, in which case your insurance will be billed. You should be aware of your insurance coverage, contract limits, and authorization. Our office will verify coverage prior to initial consultation whenever possible and do all we can to keep you within your contract limits. **IF YOU RECEIVE A PAYMENT DIRECTLY FROM YOUR INSURANCE COMPANY PLEASE LET US KNOW**.

CO-PAYMENTS: All co-payments will be collected at the time of service.

DELINQUENT ACCOUNTS: All accounts are due and payable within 30 days of services rendered. A $25.00 returned check fee applied to any check returned by the bank. Any accounts left unpaid after 120 days will be turned over to an agency for collection follow-up.

MEDICAID WAIVER: I ____ do ____do not (check one) have Medicaid (DSHS) insurance coverage (either primary or secondary). If I do, I understand that if my Medicaid plan does not cover certain services provided, I am responsible for any balance due.

PATIENTS WITHOUT INSURANCE: Please see our billing manager or assistant for payment arrangements.

I request that payment of authorized benefits from my primary insurance and/or secondary insurance be made to South Hill Physical Therapy, Airway Heights Physical Therapy, Physical Therapy North, Valley Physical Therapy, and/or Division Street Physical Therapy. I hereby give permission to the above office to treat me as prescribed by my physician.

Patient Name: _____

Signature: _____

Relationship to patient: _____

Date: _____