EXECUTIVE PHYSICAL THERAPY, INC.

247 Mountain Ave., Berthoud, CO 80513

EXPT Patient Financial Policy

We find that communication with our patients regarding our financial policy assists us in providing the best of service to you. If you have medical insurance, we will offer our assistance in helping you receive your maximum benefits. In order to do that, we need your help and understanding.

As medical providers, our relationship is with you, not your insurance company. All charges are your responsibility. You will be requested to pay your co-payment at the time of the service. In some cases, we may be able to determine your coinsurance and deductible. In that case, coinsurance and deductibles are due at the time of service.

If you have insurance with which we participate, we will bill your insurance company for you. If you fail to provide the required insurance information needed to file a claim on your behalf; you will be responsible for your balance. We will require detailed information and a copy of your insurance card to be able to provide this service. Many insurance companies require referral or preauthorization for medical services. A copy of your card will help us to obtain these necessary approvals from your insurance company. We will notify you sixty (60) days after the date of service if we have not received payment from your insurance company.

Charges for medical services are due and payable at the time of the service. A Patient Financial Services Representative will be made available if other financial arrangements are required. We do accept Visa and MasterCard. Accounts unpaid 90 days past the date of service are considered delinquent and subject to collection proceedings. You will be charged a $35 fee for any returned check. **Effective October 1, 2008**: We require a 24 hour notice for cancelled appointments. There will be a $25 fee for missed appointments or cancellations with less than a 24 hour notice.

If you have any questions regarding this financial policy, please contact us at 970-532-2533.

Thank you.

I have read and understand the above.

Print Name: _____

Signature: _____ Date: _____

RELEASE OF RECORDS

I Authorize Executive Physical Therapy to furnish medical information regarding the treatment of my current injury/illness to any or all of the following: physicians or physical therapists involved in my treatment, Medicare, my insurance carrier, or my employer (for work related injuries).

Date: _____ Signature: _____

HIPPA PRIVACY PRACTICE NOTICE

I acknowledge receiving a copy of the HIPPA Privacy Practice Notice.

Date: _____ Signature: _____