Thank you for choosing Registered Physical Therapists Inc.
Please review our Financial Policies below.

As a courtesy, we have contacted your health insurance on file, if applicable. Please see below for your **ESTIMATED** patient portion/benefit. **THIS IS NOT A GUARANTEE OF COVERAGE**. Please contact your insurance company to verify this information.

PATIENT NAME_____________________________________ DOB _______________

This box does not apply to you because: ○Auto ○Workers Comp ○No Insurance **(Skip to arrow and sign)**

Please be aware that benefits listed below are current as of: ___________ (Date RPT contacted insurance)

○ PRIMARY

PAID AT _________% WITH A ___________ COPAY or COINSUR.

DOES DEDUCTIBLE NEED TO BE MET PRIOR TO ABOVE COVERAGE? Y N

DED $_______________ MET $ _______________

FAMILY DED $ ________________ MET $ ________________

OOP $ _______________ MET $ _______________APPLIES? Y N

FAMILY OOP $ ________________ MET $ ________________

VISIT LIMIT:

○ SECONDARY

PAID AT _________% WITH A ___________ COPAY or COINSUR.

DOES DEDUCTIBLE NEED TO BE MET PRIOR TO ABOVE COVERAGE? Y N

DED $_______________ MET $ _______________

FAMILY DED $ ________________ MET $ ________________

OOP $ _______________ MET $ _______________APPLIES? Y N

FAMILY OOP $ ________________ MET $ ________________

VISIT LIMIT:

If You….

- Have a **Copayment**
  - It is due at the time of service.
- Have a **Deductible** (that is not met)
  - We will collect toward the estimated deductible portion based on your insurance's allowed amounts then will bill you for any remaining balance. Please be aware the amount varies depending on insurance plan. You could be responsible for $70-$350 per visit. Contact your insurance if you have questions.
- Have a **Co-Insurance**
  - We will collect toward the estimated co-insurance and bill you for any remaining balance.
- **Do Not Have Insurance?**
  - Please ask to speak to your account manager about other options. Your treatment and recovery is our highest priority.
- **A Balance Due?**
  - Go to www.rptutah.com and use our secure online system.
  - Pay at the front desk when you check in for your next appointment.
  - Additional Questions? Ask to speak to your account manager. They can review your account and set up payment arrangements.
    - Your account manager can be reached by contacting any RPT office.

I have read and agree to the terms above and to the full Financial Policy on the reverse side of this page. I understand that I am fully responsible for payment to RPT. The above is an estimate, and claims could process differently. I have reviewed this form and can request a hard copy of RPT's full financial policy for my review.

Responsible Party Signature ____ Date _______________

Relationship to Patient (if other than Self) _____________________

REGISTERED PHYSICAL THERAPISTS, INC. FULL FINANCIAL POLICY

Please read each section below for our full financial policy.
If you have questions, please ask.

INSURANCE INFORMATION

We accept most insurance plans and as a courtesy, RPT will submit claims to your health insurance company for you after each visit. If needed, we will re-submit these claims to ensure payment of your benefit for covered services. You are responsible for all out of pocket expenses (copays, co-insurance and deductibles). We will estimate the co-insurance percentages based on what we expect the insurance company to pay. Because this is an estimate and not an exact figure, there is a possibility that you will still be responsible for an additional balance and/or that you may be due a credit refund if you have overpaid. Your insurance company may contact you for information needed to pay your claims. Please do not ignore the request. Appropriate attention will help avoid delays in processing your claims.

REVIEW YOUR "SCHEDULE OF BENEFITS"

We urge you to review your insurance policy's "Schedule of Benefits". It will help you understand the agreement you have with your insurance company. You should call your insurance company with any questions regarding your policy/coverage of outpatient physical therapy. You should understand your policy's deductible, copayment, co-insurance, and visit limitations. As a courtesy, we will also verify your coverage, but we will not guarantee the accuracy of the information we receive. Your insurance policy is a contract between you and your insurance company. You are responsible to know your level of coverage, and you are ultimately responsible for the full payment of your bill.

CHANGES IN COVERAGE

It is your responsibility to inform us of any and all changes of insurance coverage during the course of treatment. Failure to do so may result in denial of coverage by your insurance company.

SECONDARY INSURANCE

If you have a secondary insurance we will submit claims to your secondary health insurance company as a courtesy to you.

MINORS

A parent or legal guardian must accompany the minor patient at the time of the initial visit. The parent or legal guardian that accompanies the minor patient to the clinic will have full responsibility for the payment of the minor's bill as outlined in the above financial policy.

PERSONAL INJURY, LIABILITY, AUTO, OR INVOLVEMENT OF AN ATTORNEY

In the event your claims are denied by the liability carrier or that the personal injury protection benefits are exhausted, we will file claims with your personal health insurance policy. If your personal insurance policy denies the claim for any reason, you are responsible for the full payment of your bill.

STATEMENTS

Statements are sent out monthly. Statements will show any activity on your account including: new billing, payments (insurance or patient), adjustments and finance charges, if any. Dates of service paid in full will not appear on future statements. In addition, interest will accrue on all unpaid patient portions after 30 days at the rate of 18% per annum (1.5% per month) until paid in full.

PAYMENT

All patient portion; cash, private pay accounts, copayments, co-insurance and deductibles are due at the time of treatment. We accept cash, check, VISA, MasterCard, Discover card and American Express. A $30.00 service charge will be charged for all returned checks. We will work with you to set-up a customized payment plan if necessary. If you have any concerns, please ask.

COLLECTIONS

We will work with you to avoid sending your account to collections. In the event of default on your account, your account will be referred to a third-party debt collection agency. You will be responsible for the unpaid balance and an additional collection fee of 40% of the principal amount owing as allowed by Utah Code Annotated, sec. 12.1.11. The terms of this paragraph shall apply to all amount(s) incurred by your or by any individual for whom you have legal responsibility. You will be responsible for collection and/or attorney's fees and court costs. If payment arrangements are not kept up on a timely basis, we will proceed to send your balance to our collection agency.