ORTHOPEDIC PHYSICAL THERAPY, INC.
2000 BREMO RD., SUITE 202, RICHMOND, VA 23226
Ph: 804-285-0148
www.orthopedicptinc.com

INSURANCE

You are responsible to know the details of your insurance benefits, i.e. requirements such as pre-certification or authorization, either from referring physician or primary care physician. On your first visit, your insurance coverage will be verified. After verification of your coverage has been made, the receptionist will discuss your co-payment amount due at each visit. **WE DO NOT BILL FOR COPAYS**. Each time you come in for your appointment, please pay your co-pay before starting treatment.

BILLING

Medical Reimbursement Associates handles some of Orthopedic Physical Therapy's billing. Self-pay, Aetna, Workman's Comp, and United HealthCare, are handled in our office. You will receive a statement of charges and payments after approximately 2 weeks and thereafter every 27 days. You can contact Medical Reimbursement Associates at 378-3260 with any questions regarding your statement. In addition, the Office Manager of OPT, Inc. will always be available to help answer your questions if needed. The filing of insurance claims is a **courtesy** that is extended to the patients of Orthopedic Physical Therapy. If your insurance company requires a co-payment, this will be collected each visit. You are also responsible for payment of your deductible each calendar year if this has not been fulfilled when you begin therapy. Furthermore, if you are in litigation or have been in an auto accident and are relying on third party insurance, payment for physical therapy services is your responsibility at the time of each visit. If necessary, a payment plan may be set up with the Office Manager. **Regardless of your situation, you are ultimately responsible for payment of your bill.** All payments may be made by check, credit card or cash.

CANCELLATIONS

Cancellation of appointments must be made 24 hours before scheduled appointments. Unless there are unusual circumstances, a cancellation fee of $115.00 will be charged. Payment for this fee will be collected from the patient on their next visit. If you miss an appointment without contacting Orthopedic Physical Therapy to cancel, emergencies notwithstanding, a missed appointment fee of **$115.00 will be charged.** If this occurs again, the patient will be charged and may be taken off our schedule and placed on a waiting list.

LITIGATION ACCOUNTS WITH ATTORNEYS

Orthopedic Physical Therapy **WILL NOT HOLD LITIGATION ACCOUNTS FOR SETTLEMENT**. You must make arrangements with the Office Manager for payment of these accounts.

COPIES OF RECORDS

All requests for copies must be accompanied by a signed release. Upon receipt of copies, payment for said copies are due in full. A fee sheet is available.

PURCHASING SUPPLIES

When purchasing a supply from Orthopedic Physical Therapy, payment must be made at the front desk when picking up the supply. The patient will receive a receipt that can be used for insurance purposes. Orthopedic Physical Therapy does not file claims with insurance companies for supplies. Payment for custom orders is required at the time order is placed.

NON-COVERED PROCEDURES

Services not covered by your insurance company (i.e. intramuscular stimulation, etc.) are your responsibility. If your therapist suggests one of these procedures, the fee will be your responsibility. Please sign the waiver form and make your payment prior to treatment.

MEDICAL SERVICES AGREEMENT

I hereby authorize Orthopedic Physical Therapy, Inc. to render medical services to me/my minor child named _____ and to release any information regarding my medical history, diagnosis, and treatment of me (or child) to my insurance company regarding my claim. I understand that I am financially responsible for all the charges arising for the treatment of the above-named patient. If this contract is referred to an attorney for collection, I agree to pay all attorney fees and court costs incurred. There will be a $25.00 charge for checks returned due to insufficient funds. I hereby consent to any medical treatment and evaluative procedures as the licensed physical therapist considers being necessary or advisable. I understand this may include, but not limited to orthopedic evaluation, modalities or manual treatment. I also hereby consent to have my medical records sent to the following:

PCP: _____ **Referring MD:** _____

Other Entity: _____ _____

Signature of Patient or Representative: _____ Date: _____

Acknowledgment of Privacy Practices Notification

Our Notice of Privacy Practices tells you how our practice may use and disclose medical information about you. From time to time, the terms of our notice may change. If we change our notice, you may ask for a revised copy. I _____ (insert name of patient or legal guardian) have been given a copy of the Notice of Privacy Practices as provided by Orthopedic Physical Therapy, Inc. I understand that I may ask questions about any information contained in the Notice of Privacy Practices, and I also understand I may request a copy for my records.

Patient Signature: _____ **Date:** _____

Authorized Representative of Patient or Legal Guardian: _____

Relationship to Patient: _____ **Date:** _____