Financial Agreement:

The patient will be responsible for all copay, deductible and coinsurance amounts due at the time services are rendered. Our office accepts cash, checks and Visa/MasterCard/Discover/American Express credit and debit cards.

I understand that this office will make every attempt to obtain payment from my insurance carrier including Medicare and/or other third party payer. I acknowledge and understand that payment for services may be denied by my insurance carrier, including, but not limited to, pre-existing conditions, routine, experimental, not reasonable or necessary, or work related reasons. I authorize and direct my insurance carrier to pay benefits to IROC Physical Therapy, LLC for services rendered to me, regardless of the carrier's policy concerning this office. This is a direct assignment of my rights and benefits under this policy.

Any balance on my account that remains unpaid for more than 60 days may be assessed a rebilling fee of $25.00. If a balance remains unpaid for more than 90 days, the account may incur an additional $50.00 rebilling fee. Once a balance goes unpaid past 100 days, the account may be turned over to a Third Party Collections Service.

You agree that you will pay any interest that can be added at the current legal rate as well as all collection fees, returned check fees, attorney fees and court costs incurred for the collection of all sums due. Payment plans are available up to but not exceeding 6 months. Any missed payments will be subject to a 5% interest charge per month as well as the late fees indicated above.

Additional Fees: A fee of $65.00 will be charged if cancellation is less than 24 hours. A fee of $90.00 will be charged if an appointment is a no-show. A fee of $25.00 will be charged for any returned check. An equipment fee of $45.00 each session will be charged if dry needling is indicated for your plan of care. A one-time equipment fee of $85.00 will be charged if laser treatment is indicated in your plan of care. These fees are not covered by insurance. Any supply or durable medical equipment provided to you will exclusively be your financial responsibility and will need to be paid for at the time of purchase. I authorize and direct my insurance carrier to pay benefits to IROC Physical Therapy, LLC for services rendered to me, regardless of the carrier's policy concerning this office. This is a direct assignment of my rights and benefits under this policy.

A photocopy of this assignment shall be considered as effective and valid as the original. My signature affixed here may be kept on file to suffice for any signatures required on insurance claim forms. In addition, I authorize IROC Physical Therapy, LLC to release pertinent information to my insurance carrier(s) and the Indiana Department of Insurance concerning my condition and treatments rendered. I have read this financial policy. I understand and agree to comply with this financial policy. I authorize the release of any medical information required throughout the course of examination and treatment and permit payment directly to IROC Physical Therapy for any monies due for the services rendered.

Patient Name (Printed): ____ ________________
Date

________________________________ ________________________________ ________________
Print Name of Responsible Party Signature of Responsible Party Date

____ ____
Signature of IROC Physical Therapy Representative Date