AXIS PHYSICAL THERAPY, INC.

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

PAYMENT AT TIME OF SERVICE

If you are covered by a private insurance carrier, you are responsible for your deductible, co-insurance, and co-payment at the time services are rendered unless otherwise arranged with our office. If you are covered by Medicare without a secondary insurance, you are responsible for your deductible and co-insurance. If you are covered under a workman's compensation claim, you are responsible for any no show/late cancellation fees (see ADDITIONAL FEES). If you are a self-pay patient, $125 for initial evaluation and $100 per physical therapy session will be collected at the time services are rendered. We accept cash, check, Visa, MasterCard, Discover, and American Express.

REGARDING INSURANCE

We bill your insurance on a weekly basis and payment may be mailed directly to you. If you receive a check from your insurance carrier, please notify the office immediately. Please be aware some, or perhaps all of the services provided may be "non-covered" services and not considered medically necessary under your medical insurance. Although our office staff verifies your benefits with your carrier, sometimes payment is denied or withheld. Please be aware you are responsible to know and understand your medical benefits, and you are responsible for full payment on your account regardless of any disputes with your insurance carrier.

ADDITIONAL FEES

MISSED APPOINTMENTS:	If you are inconsistent in keeping your scheduled appointments we reserve the right to charge you at the rate of a normal office visit (this includes any Work. Comp. case). Please be aware that most insurance carriers do not cover "no show" or "late cancellation" fees. Please help us serve you better by keeping your scheduled appointments.
RETURNED CHECKS:	There is a $25 fee for checks returned for insufficient funds.
INTEREST:	Interest fees compounded at 12% per annum (1% per month) will be assessed after 60 days to unpaid balances.

If you have any questions regarding your account at any time, please ask our office staff.

Thank you for understanding our Financial Policy.

I have read, understand and agree with the Financial Policy.

X_____ Date_____