Roaring Fork Physical Therapy
Billing, Collection and Appointment Policies

Scheduling: Patients will be scheduled at RFPT per their request based on availability. Please be on time for your appointment, ***otherwise the appointment may need to be shortened or rescheduled.***
_______ (initial here)

Late Cancellations & No Show Fees: Patients who do not show up for an appointment or who cancel with *less than 4 hours notice* will be charged **$50**. **This fee is not billable to insurance and is due at the next appointment.**
_______ (initial here)

Charges: Charges for services rendered are based on procedures given to the patient in a given day, based on the professional judgment of the treating therapist. Charges are based on reasonable and customary charges for the region.

Fees for all supplies, except some braces, are charged directly to the patient. We do not file insurance for supplies unless it is a worker's compensation claim.
_______ (initial here)

Billing: RFPT will bill each patient's insurance company on the condition that we are provided with any and all insurance information. The patient must also inform RFPT about any policy changes during the course of therapy. ***Co-payments, co-insurance, and deductible amounts are due at the time of service.*** Weekly payments will be accepted with a credit card and signature on file.

Patients are ultimately responsible for the payment of all fees for services provided them. Unpaid, overdue accounts will be sent to the American Credit Bureau. Collection fees and finance charges *will* be assessed.
_______ (initial here)

Appeals: RFPT will appeal insurance reimbursement **ONCE**. Any need for further appeals will be up to the patient, and payment will be expected by the patient to RFPT.

Privacy Policies: Copies of our Health Information Practices (privacy policies) are on the front desk. You may pick up a copy at any time. By signing below, you acknowledge that a copy of these privacy policies has been made available to you and that RFPT reserves the right to amend them.

This is an open clinic where your treatment might be seen and overheard by others. If you desire privacy and anonymity, please let your therapist know that you'd like a private room.

I have read and understand the above policies and agree to the terms:

_______________________________ _______________________________ ____________
Patient Name (printed) Signature of patient Date

_______________________________________ ___________________________
Signature of patient representative Relationship to patient
(if patient is a minor or otherwise unable to sign)