Thank you for choosing us as your healthcare provider.  We are committed to providing you with the best possible medical care at the lowest possible cost.

**Insurance**

* We will verify your benefits and help you understand how physical therapy is covered.  However, verification of benefits is not a guarantee of payment by the insurance company.
* As a courtesy, we will bill your health, auto, or worker’s compensation insurance company.  If a problem arises, you may be asked to assist us in contacting your insurance company.

**Missed Appointments**

Because we reserve time for you to receive physical therapy services, it is important for us to know if you are not going to be able to attend so that we can offer that time to someone else.  We ask that you please give us a 24-hour notice if you cannot make your scheduled time.

In respect to other patients and schedules, canceling within 24 hours of scheduled appointment time will result in **$25 cancelation fee.** (Rescheduling will be at clinic convenience.) If we are not notified about the cancelation before the visit, it will be marked as a no show.

No shows result in a **$25 fee**. Two no-shows will result in **discharge from therapy** with notification to referring MD.

**Do not respond to automated messages. Call or text the clinic number: 985-900-2365**

**Payment Responsibility**

After verification of benefits with your insurance company, your responsibility for Physical Therapy services is as follows:

Verification of benefits does not guarantee payment of direct access or all physical therapy services.  If your insurance denies payment of services, you will be charged our private pay rates of $100.00 for your evaluation and $75 per visit after that**.**

**Financial Obligations and Payment Options**

Payments are expected **at the time of Service**.  This includes:

* Co-pay/Co-insurance per your insurance plan
* Deductibles that your insurance applies to your coverage
* For minors: the signing parent of this form is the guarantor of payments for treatment

We accept Cash, Checks, VISA, and Mastercard.

  Payment at each visit with cash, check, or credit card

  Payment at the end of each week with cash, check or credit card

  Payment Plan with Credit Card on File and an initial down payment

I have read Flex’s financial policy and agree to comply.  My insurance benefits have been explained to me and I understand that I am responsible for any co-pay, co-insurance and/or deductible required by my insurance policy.

Printed Name:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_