**Patient Payment Policy**

Maple City Physical Therapy, PLLC is committed to providing you with the highest quality of care. In order to maintain that level of excellence, we ask that you review and sign our patient payment policy.

**Payment:** Co-payments and estimated deductible payments must be rendered at the time of your visit. Cash, credit card, and check payments are accepted. Returned checks will be subject to a $40.00 additional charge. Statements generated for co-pays unpaid at the end of your case are subject to a $5.00 administrative fee. Unpaid statements will be forwarded to our outside collections agency and will be assessed a 25% collections fee.

**Insurance Coverage:** Our staff will assist in verifying insurance coverage in advance of your first appointment and will work with you if a special payment plan is required. Final insurance coverage verification is always the patient’s responsibility.

**Self-Pay Patients:** For the convenience of our patients, Maple City Physical Therapy offers a self**-**pay option for those without insurance benefits.

**Auto Accident and Workers Compensation Patients:** Our office does accept motor vehicle and work-related accident/injury patients. To expedite the billing process, please arrive with all pertinent claim information at your initial visit. If the worker’s compensation or no fault (motor vehicle) claim is denied, we will bill your participating health insurance plan. If we do not participate, or there is a remaining balance, it will be patient responsibility to pay. Cancellation and No-Show Policy: We value your time as our patient, and we hope that you will value the time of our therapists by calling our office if there is a reason that you are unable to keep your appointment. Cancellations are required within 24 hours of your appointment. If you fail to come to your appointments, the following policy is enforced:

• **First No-Show/late cancellation:** you will receive a phone call informing you that you missed the scheduled appointment, and be given an opportunity to reschedule

• **Second No-Show/late cancellation:** you will receive notification that you have now missed (2) visits without notifying the office in an appropriate time frame, and you will be charged a $20.00 fee for a cancellation and $50.00 fee for a no-show.

• **Third No-Show/late cancellation:** you will receive notification regarding your no show/cancel history and you will be charged a $50.00, and may result in dismissal from clinic. 2 South Main St. MapleCityPT@gmail.com 100 Loder Street Andover, NY 14806 607-324-9344 Hornell, NY 14843 Fax 607-324-9345

**• If your appointment is scheduled outside of normal business hours, fees above will be $50.00 per event.**

• If you schedule an appointment on the day following Thanksgiving, December 24, 26, 31, or January 2, and no show or do not provide 24 hour notice of cancellation, the fee will be $50.00 for the missed visit.

• This fee will be paid at your next visit. This fee is NOT covered by your insurance and will be your responsibility, no matter the insurance coverage.

**If You Are Late:** Please give us a call to be sure you can still be seen, and check to see if rescheduling is necessary. Excessive last-minute cancellations will be subject to the above fee schedule.

**Insurance Information:** Maple City Physical Therapy will bill insurances that we contract with to receive payment for services rendered. Most insurance companies will cover a percentage of physical therapy services, but please be aware that many insurance companies also require an authorization/referral from your physician for reimbursement of physical therapy services. We recommend that you contact your insurance company to familiarize yourself with your individual policy.

• Find out what your physical therapy coverage is and ask about your physical therapy and wellness benefits

• Find out what limitations are on your policy

• If your injury is work-related, obtain information from your worker’s compensation insurance (name of adjuster/case manager, insurance company, billing address and phone number, claim number)

• If your injury is related to a motor vehicle accident, please bring the same information as above, as well as the maximum benefit allowed.

**We ask that you pay your balances due at the time of service, so as to eliminate the need for billing. Unpaid balances will be due upon receipt of statement.**

Patient Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Parent or Guardian Signature (if patient is a minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_