Bozeman Pediatric and Sports Physical Therapy, LLC

Financial Policy

As a courtesy to you, we will file all insurance claims to your insurance carrier. A copy of your health insurance card is required; if we do not receive a copy of your card, we will not file your claim. It is your responsibility to ensure that the information we have on file is current and accurate. Failure to provide us with the information that we need to process your claim will result in you being financially liable for the services provided.

It is our policy to collect copayments and/or deductible amounts at the time of service. If you do not know your copayment or deductible amounts, we will collect payment in full. If you do not carry insurance or wish to file your claim yourself, payment in full is due at the time of service. **Any balance over 45 days will be due from you.**

Any returned checks will result in a NSF charge of $25.00.
We have a no show charge of $25.00 after 2 missed appointments with our office.

CONSENT

I hereby give my permission to Bozeman Pediatric and Sports Physical Therapy, LLC (Jennifer Wilshire, PT), to perform evaluations and treatments that may be deemed necessary in the diagnosis and/or treatment of my or my child's/dependent's condition.

AUTHORIZATION and RELEASE

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering claims for health insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, directly to Bozeman Pediatric and Sports Physical Therapy, LLC. I understand that I am financially responsible for all charges whether or not paid by insurance.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I read or had the opportunity to read, if I so chose, and understand the notice.

x_____ Date: _____

Signature of Patient, Responsible Party or Parent if patient is a minor