APEX
PHYSICAL THERAPY
AND MOVEMENT CENTER

7941 New Chipping Lane, New Kent, VA 23124
Phone: 757-969-5200 Fax: 757-969-5201

FINANCIAL AGREEMENT

Effective October 1, 2018

As a courtesy, APEX Physical Therapy will bill your insurance companies for services provided. However, it is our policy that the patient is responsible for any payment due, should your insurance not pay. In order to bill insurance, the patient must provide us with the necessary information. The patient is responsible for understanding their insurance coverage in relation to our outpatient physical therapy services. We will verify insurance benefits as a courtesy, however, verification of benefits is **NOT** a guarantee of payment, nor can we ensure the accuracy of information provided to us from your insurance carrier.

Your patient responsibility, typically in the form of deductible, copay, or coinsurance, is set forth by your insurance company and it is our responsibility to collect it for each date of service. We have no control over setting your patient responsibility amounts, nor can we change or waive them. If at any point you overpay your responsibility due to inaccurate information, we will refund the amount due.

PLEASE NOTE: Payment due for services rendered is to be paid at each visit.
Please bring your preferred payment method for each visit. We accept cash, check, and credit card (VISA, MasterCard, Discover, American Express).
INITIAL: _____

Missed Appointment Fee
There will be a $25 missed appointment fee applied to any appointment that is missed or not cancelled within 24 hours of the appointment time. Cancellations must be called in to our office directly or left on our voicemail if the office is closed.
INITIAL: _____

Authorization to Release Information
I authorize APEX Physical Therapy to release any information deemed appropriate concerning my condition and care to my referring physician, any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred as a result of professional services rendered in our facility and hereby release APEX Physical Therapy of any consequence thereof.
INITIAL: _____

Notice of Assignment
I authorize and direct payment of any medical expense benefit to APEX Physical Therapy as payment toward the total charges for professional services rendered.
INITIAL: _____

I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

Printed Name: _____

Signature: _____ Date: _____

Relation to Patient: _____