# OFFICE POLICIES

## IGNITE PHYSICAL THERAPY & WELLNESS CENTER, LLC

The following is a list of office policies. Please read them carefully and sign below. If you have any questions or concerns, please ask for clarification. A copy is available at your request.

*Insurance:*

We are only accepting a limited number of health care insurance policies.

Important note: Your insurance company may decide that certain treatments are not necessary and may choose to deny payment for these services. Any treatment provided is in your best interest and is an integral part of your recovery. We will appeal this decision; however, if it is not ruled in our favor, you will be responsible for the outstanding amount.

*Missed Appointments:*

When you book an appointment that time is reserved for you. If you are unable to attend you are required to give 24 hour notice so that the time can be used to schedule another appointment with someone else. Failure to give this notice will result in you being billed the self-pay rate for the missed appointment. The rate for the missed appointment will be $60.00. Even if you have insurance that I accept it is your responsibility to pay for the missed appointment as your insurance will not.

*Billing:*

Payment is expected at the time service is rendered. In some cases a monthly statement will be sent out if discussed with me ahead of time. Failure to pay within 30 days of the statement being issued will result in no further appointments being made until such time as your account is paid in full. This policy is applied to all appointments both those attended and missed without giving notice.

If I am accepting your insurance it is expected that they will pay within 30-90 days of being issued the claim. Failure on their part to pay me will result in you receiving a bill for the outstanding balance. You will then have 30 days to correct this with the insurance company or pay me the outstanding balance. If you have received a check from your insurance company for the services we have provided, you obligated to turn that check to us within 30 days of the receipt. Failure to do so may result in collection agency and further fees.

*Confidentiality:*

All information that you provide is kept confidential. The normal Policy is to provide the referring physician and your insurance company, if they are responsible for payment of services rendered, with medical information relating to the current treatment. Your signature on the registration form allows me to provide information to the referring physician and the insurance company. Release of information to any other party would require you to sign a release of information document.

*I have read the above policies and agree to comply with them.*

Patient: ______________________________________________ Date of Birth: _________________________

Signature: ____________________________________________ Date: ________________________________