100 W. Liberty Street, Ste 170
Reno, NV 89501
775-470-5881
Fax 775-470-5883
sportsandperformancept.com

Payment and Insurance Policy

FINANCIAL POLICY:
It is our policy in this office to maintain your account on a current basis. Charges for treatment are due at the time the service is provided unless we are preferred providers of your insurance plan. We ask that you make copayments, co-insurance and deductibles at the time of each visit. Your balance must be paid in full on or before the 1st day of the following month, and any unpaid balance will be considered past due on the 5th of the month.

PATIENT'S RESPONSIBILTY:
It is the patient's responsibility to pay for any balances due in a timely manner for services rendered, regardless of insurance claims status. _____ (Initial)

It is the patient's responsibility to:

- Understand their insurance policy, and to ask questions when they don't.
- Obtain a referral indicating medical necessity for physical therapy services.
- Pay co-pays, co-insurances, and/or deductibles at time of service.
- Promptly pay any patient responsibility indicated by their insurance carrier.
- Contact their insurance carrier when claims have not been paid.
- Obtain updated referrals or prescription for physical therapy when there has been more than a 30-day lapse in care or when their referral is dated more than 30 days previous to their 1st visit.

INSURANCE PATIENTS
ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize Sports & Performance Physical Therapy to furnish information to my insurance carrier(s) concerning this treatment and I hereby assign all payment for services rendered to Sports & Performance Physical Therapy. _____ (Initial)

MEDICARE PATIENTS – (*please provide card)*
Have you had any PT this year provided in your home or in another outpatient clinic? ☐ Yes ☐ No _____ # of visits
Do you currently have Medicare home services? ☐ Yes ☐ No
Medicare ID:_____

SELF PAY PATIENTS:
For patients without insurance or with insurance we are not contracted with, we offer self-pay rates which must be paid at the time of service. _____ (Initial)

VOLUNTARY TERMINATION OF TREATMENT:
It is also the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable. _____(Initial)

I have read the above information and **I UNDERSTAND MY RESPONSBILITY FOR THE PAYMENT OF MY ACCOUNT**.

_____ _____
Patient or Guardian Signature Date