Freedom
PHYSICAL THERAPY
& SPORTS REHABILITATION
Freedom from Pain • Freedom to Live Life Fully

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Compassion with High Integrity

Strong Communication Skills

Orthopedic and Musculofascial Specialists

Certified Clinical Instructor Facility for PT & PTA students

Dedication to Teaching and Furthering Professional Education

**Insurance Billing and Collection Guidelines**

Here are some very important things for you to know about Freedom Physical Therapy and Sports Rehabilitation, LLC and our insurance billing policies:

Insurance Benefits: It is important for you to know your coverage before coming to your first appointment. Please contact your insurance company or case manager prior to your visit and fill out the answers to the questions on the following pages. **This information will be required at check in.**

Freedom Physical Therapy and Sports Rehabilitation, LLC cannot guarantee the accuracy of the benefits quoted to our office therefore, we will not be responsible if the insurance carrier processes your claim differently than expected. This is another reason why you are required to contact your insurance company prior to your visit.

Appointment: Please come to your appointment with a valid ID, your insurance card and with the Insurance Billing Information sheet completely filled out as well as all other papers filled out and signed. After your appointment we will collect any outstanding deductibles, co-pay, and/or coinsurance for covered services. Each appointment will be approximately 60 minutes and you will be contacted by our receptionist the previous day as a reminder of your appointment. Freedom Physical Therapy and Sports Rehabilitation, LLC requests a 24-hour cancellation notice. A $30.00 fee will be charged directly to you, the patient, if notice is not given or a "no show" is made. Please be aware that insurance companies do not pay these fees. The patient is responsible to make every scheduled appointment and to pay all associated fees with that appointment including cancellation and "no-show" fees. **THREE "NO SHOWS" OR CANCELLATIONS WILL RESULT IN A DISCONTINUATION OF PATIENT CARE.**

Patient Agreement: You must understand that you are responsible for all fees regardless of insurance coverage and that all charges are due at the time of services.

If your insurance company denies your claim or pays less than expected, you will be responsible for paying the balance, in full, within 60 days of date of service. In the event of patient nonpayment and/or a delinquent account you will be sent to collections and charged the associated fees and interest. In the event your account is sent to collections please review our collections policy.

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**Primary Insurance Information**

Last name_____ First_____ MI_____

SSN#_____ DOB_____ Relationship to patient_____

Employer name_____

Insurance Co. name_____ Policy #_____ Group #_____

Do you have a Co-pay? _____ Co-pay amount $_____ Have you met your deductible?_____

Deductible amount $_____ What is your insurance coverage? (Example20/80)_____

**Secondary Insurance Information** (do you have another type of insurance?)

Last name_____ First_____ MI_____

SSN#_____ DOB_____ Relationship to patient_____

Employer name_____

Insurance Co. name_____ Policy #_____ Group #_____

Do you have a Co-pay?_____ Co-pay amount $_____ Have you met your deductible?_____

Deductible amount $_____ What is your insurance coverage? (Example 20/80)_____