

Freedom

PHYSICAL THERAPY & SPORTS REHABILITATION

Freedom from Pain • Freedom to Live Life Fully

phone: (907) 335-1155

fax: (907) 335-1156

6383 Kenai Spur Highway
Kenai, Alaska 99611

web: www.akfreedompt.com

email: akfreedompt@gmail.com

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.

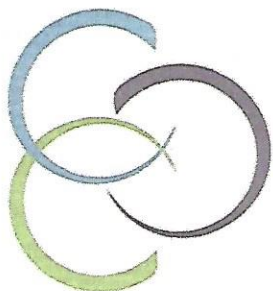
Appointment: Please come to your appointment with a valid ID, your insurance card and with the Insurance Billing Information sheet completely filled out as well as all other papers filled out and signed. After your appointment we will collect any outstanding deductibles, co-pay, and/or coinsurance for 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.

Highly Trained and Specializing in:

Complex Pain and Movement Disorders • Sports and Work-related Injuries (e.g., sprains, strains, fractures) • Pain and functional limitations in the neck, extremities and back • Balance problems with increased fall potential
Rehabilitation before and after surgery (e.g., extremities, neck, back) • Research preferred Manual Techniques and Customized Therapeutic Exercises • Total Joint Replacements (knee, hip, shoulder & disc)
Communication that unclutters and demystifies medical language • State-of-the-art equipment (e.g., Sports & Balance, Class 2 Erchonia® & Class 4 LightForce® lasers)



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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? (Example 20/80) _____

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) _____