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Office Policies and Procedures

We have developed this information to make you aware of our billing policies at the time of your initial office visit. Please review these policies carefully. By signing this form, you are agreeing to abide by the terms of our office policies and procedures.

Physical therapy services are reimbursed under the provisions of most health insurance policies. Our office personnel are familiar with most coverage's offered by health insurance companies, but you as a subscriber, are primarily responsible for knowing the terms of your policy. Your insurance copayments are due at the time services are rendered. If you (the subscriber) should receive a check from your insurance company that is intended for this practice (the provider) for services rendered, you should immediately remit this to our office for credit to your account. Failure to do so will result in our office billing you for the complete balance, and you will be responsible for payment of this amount in full.

Although we make every attempt to check your benefits with your insurance company, you are responsible for the correct payment after claims have processed by your insurance company for all dates of service. *Initial:* _____

Liability cases are accepted when accompanied by a health insurance plan and/or auto insurance with a med-pay plan. We will accept the insurance plan's allowable, along with the copayments and/or deductibles, as payment in full for any covered services rendered to our patients. However, once the health insurance plan indicates that it will no longer pay for physical therapy benefits, the service will no longer be considered a covered service and the patient will be responsible for services payable at the time of visit.

Worker's Compensation patients will be accepted according to the Worker's Compensation Law enacted in 1992. Should your claim be denied by the RI Worker's Compensation Court, you will be responsible for the payment of your account. You may then submit your paid invoice to your 3rd party insurance for consideration of payment. Failure to attend physical therapy may jeopardize your worker's compensation benefits.

Please call your customer service representative if you have specific questions relative to your plan. Please indicate the insurance plan you currently have in effect:

Medicare Patients

Medicare patients who do not have supplement insurance will be billed for their yearly deductible and 20% of the Medicare allowable. If Medicare denies payment, the patient will be billed for 100% of the allowable. Failure to pay constitutes Medicare fraud.

Medicaid Patients

Medicaid does not pay for physical therapy in a private practice.

No Show, Cancellation, and Late Policy

In order to maintain efficient patient scheduling, we developed this policy. Your scheduled appointment is reserved for you. If you are unable to keep your appointment you must cancel it at least 24 hours in advance by direct communication with our office or voicemail. A \$25 fee will be charged for all missed appointments not canceled with a 24 hour notice. This fee must be paid prior to the next visit.

If you are going to be late for your appointment, you should call to inform us of your expected time of arrival. Your appointment may need to be rescheduled at the discretion of the therapist. This policy is to ensure that your late arrival will not interfere with the treatment of the patient scheduled after you.

COPAYMENTS are due at the time of service. Please contact the customer service department of your insurance company for information regarding your copayment amount. Payment can be made via cash, credit card, or check. There will a non-refundable \$25 fee for any returned check.

DEDUCTIBLE is the amount you pay for health care services before your health insurance begins to pay. If you have a deductible, you are required to make payments toward the deductible at the time of service. We make every effort to check your deductible accumulation at the time of your initial evaluation; however, deductible amounts may change on a daily basis, so this information may not be accurate. Should you overpay, you will be reimbursed after you have been discharged and after **all** claims for dates of service have been paid by your insurance company. We do our best to collect any allowable amount toward your deductible at the time of service; however, if there is a discrepancy in that amount, you will be billed for remaining balance.

** Your deductible amount is \$ _____ you have met \$ _____ of the deductible.

You will pay 100% of your insurance company allowable for the initial evaluation and \$ _____ for follow-up appointments until your deductible has been satisfied.

COPAYMENTS:

Initial Evaluation _____ Follow-Up Visits _____

I, _____, fully understand the contents of your office policies and procedures and agree to abide by them. I also understand and agree to pay for the charges that may be made towards my account for physical therapy services rendered by this office, consistent with the terms of my health insurance policy.

Patient or Guardian Signature

Date