Berryville
Physical Therapy and Wellness

PATIENT RESPONSIBILITY

effective 8.30.18

As a patient of Berryville Physical Therapy & Wellness, PLLC, I agree that I am responsible for any unmet deductible, co-insurance, and/or any unpaid balances. This includes all insurance companies, workman's compensation and auto claims. I guarantee I will pay the amount deemed "patient responsibility"

***As a courtesy, we make every effort to know your insurance benefits when you are a patient here but every policy varies in coverage. Therefore it is your responsibility to confirm benefit information.

Co-pays and Co-insurance are due at time of service. *There is a $25 returned check fee that insurance is not responsible for.

*Medicare patients who do not have supplemental coverage are responsible for any unmet deductible, non-covered services, or co-insurance amounts. Some supplemental policies have a co-pay or deductible of their own; patients are responsible for that amount.

*I authorize that the payment of my insurance benefits be made directly to BPTW for all services delivered; if I am paid directly I will promptly pay BPTW all monies paid to me.

*I certify that all information I have provided to BPTW is accurate and truthful.

*All uninsured patients and patients who are denied physical therapy coverage by their insurance company are responsible for our cash price.

*If the patient is unable to pay the full amount of his/her bill payment arrangements may be made on a case by case basis.

*I understand if payment arrangements have not been made, and my account is still outstanding (60) days from the 1st billing cycle, my account may be referred to a collection agency or and attorney for collection. I agree to pay all fees of collection, including but not limited to, 40% to 50% collection fees depending on the account balance and age of the account, registered mail fees, court costs and attorney fees actually incurred in the collection of the amount whether or not a suit is filed, and any other fees or cost incurred during the collection process.

*I understand that I am responsible for my account even if I receive a late notification of my outstanding balance. In this case, I will not be referred to a collection agency and will be allowed to make arrangements for a payment plan.

When all payments have been made by the account responsible and the insurance company(ies), if there is a credit or debit balance of less than $1, I understand that Berryville Physical Therapy & Wellness will consider the account closed and will neither pursue collection nor refund the balance. Records are kept a minimum of 6 years.

"NO SHOW / LATE CANCELLATION" POLICIES

At Berryville PT and Wellness, we value customer loyalty and therefore do not have "No Show" fees.
We see your appointment as an agreement between you and your therapist.
We encourage you to attend appointments because we know that
***those who benefit from therapy are those who attend* their appointments.**
We do not overbook; your therapist has set aside an ample amount of time to be present for your appointment.

***We respectfully ask for 24 hours' notice if you expect you will not be able to attend your appointment. ***
This allows time for us to offer the appointment to someone in need of our services.

PRIVACY NOTICE SUMMARY

ALL MEDICAL INFORMATION ABOUT YOU IS REGARDED AS PROTECTED HEALTH INFORMATION (PHI) AND IS TREATED AS CONFIDENTIAL AND WILL BE RELEASED ONLY TO THOSE AUTHORIZED TO RECEIVE IT. Our full notice is printed and given to each patient at the time of evaluation, when updated, or upon request.

By signing below, I certify that - I have read and agree to the above statements and that I have read and/or received a copy of BERRYVILLE PHYSICAL THERAPY & WELLNESS HIPAA NOTICE.

☐ **Patient is a Minor**

Name of Attending Parent _____ Parent SSN _____-_____-_____

PATIENT NAME **PATIENT / PARENT SIGNATURE (SEAL)** **DATE**