ALPINE
PHYSICAL THERAPY AND SPORTS CARE

PAYMENT AGREEMENT

Thank you for making Alpine Physical Therapy & Sports Care your physical therapy clinic of choice. It is our goal to provide you with the best care available to achieve your physical therapy goals. We are grateful to be working with you and look forward to helping you reach your full potential.

PLEASE READ THIS DOCUMENT THOROUGHLY AND SIGN BELOW.

As a courtesy to you, we will verify your eligibility and benefits with your insurance company; however, it is your responsibility to know your full physical therapy benefits (i.e., Copay, Coinsurance, Deductible, Number of Visits Allowed) before your Initial Evaluation appointment. It is also your responsibility to know if pre-authorization for physical therapy is required from your insurance company. If we are given incorrect or incomplete information from your insurance company, you will ultimately be responsible for any payments not covered by insurance.

Please be advised that:

- *All accounts must be settled for previous cases prior to treatment of a new case.*
- *If your insurance plan requires a copay, payment is due at the time of service.*
- *If your insurance plan requires a deductible or coinsurance payment, you will receive an invoice periodically. Payments are due within 30 days of the invoice date.*
- *If your visits are not covered by insurance, or you are paying out of pocket, your Initial Evaluation fee of $150 and each Follow-up Visit fee of $100 will be due at the time of service.*

We accept the following forms of payment:

Cash, Check, or Credit Card (American Express, Discover, Mastercard, Visa)

We require that a credit card be on file for unpaid invoices, copays, and fees incurred through our cancellation policy. Your card will automatically be charged if you do not pay your invoice within 30 days or your copay at the time of service. ***As per our cancellation policy, if you cancel your appointment within 24 hours of the appointment time or do not show up for your appointment, a $50 fee will be automatically charged to your card on file.***

Credit Card Number: _____

Expiration Month/Year: ____ /____

Please initial here to confirm your understanding of the cancellation policy. _____

If it is your preferred method of payment for copays, we can automatically charge the card on file. To authorize this automatic copay payment, please initial here: _____

We understand that everyone's financial situation is different and can change at any time. If you feel that you are unable to meet the terms of this agreement, please speak to the front desk staff, and we will work with you to create a customized payment plan.

By signing this document, you agree to the terms of this Payment Agreement and are financially responsible for all charges incurred for your visits at Alpine Physical Therapy & Sports Care that are not covered by insurance. You understand and authorize us to charge your credit card on file if payments are not made by you in the timeframe stated above.

Printed Name: _____

Signature: _____ Date: _____

Relationship to Patient: _____