



**OFFICE POLICY**

**CONSENT FOR CARE & TREATMENT:** Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be design. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent to **Mosaic Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

**CANCELLATION & NO-SHOW POLICY:** We require 24 hours notice in the event of a cancellation. The charge for a cancellation without proper notice is \$75 for physical therapy visits. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.

*I have read and agree to the cancellation policy \_\_\_\_\_*

**PATIENT FINANCIAL POLICY:** **Mosaic Physical Therapy** is a participating provider for Medicare, Blue Shield, PHCS and CCN. We will gladly bill your primary and secondary insurance carriers, as a courtesy, for services rendered at our facility. You will be responsible at the time of service for payment of the annual deductible, co-payments and charges for any non-covered services and supplies.

In the event your insurance carrier denies coverage for a charge you thought was covered by your plan, you will be billed for that charge after we obtain a denial from your insurance carrier.

Most insurance plans have a "co-insurance" amount for which you will be billed for once we receive the Explanation of Benefits from your insurance carrier for services rendered. Most insurance companies do not pay 100% of the contracted/ allowed amounts leaving a co-insurance to be paid by the patient. We recommend you contact the Member Service Department of your insurance if you have questions about what is covered and amounts you will be responsible for.

In the event that your insurance carrier fails to pay for a service within 90 days, you will be billed for the unpaid charges.

Mosaic Physical Therapy offers a discounted fee for payment at the time of service. If you choose to take advantage of this discount, we will provide you with a superbill that you can submit to your insurance for re-imbusement.

Patient due balances over 30 days will assessed a 1.5% monthly (18% annual) service charge, unless other payment arrangements have previously been made with this office. (This service charge does not apply to Medicare patients.)

**MEDICARE:**

We are participating providers of the Medicare program. We do not accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying the 20% co-insurance. We do file with secondary/supplemental carriers.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

\_\_\_\_\_  
Patient/Responsible Party Signature

\_\_\_\_\_  
Date