FINANCIAL POLICY

Welcome to OrthoSport Physical Therapy & Athletic Rehabilitation. Please review our financial policy and sign below.

Insurance Acceptance Guidelines:

We participate with the following insurance companies:

Medicare/Medicare Advantage Plans	Medicaid/Medicaid HMO's
BCBS/Blue Care Network	McLaren Health Plan
Aetna/Cigna/United Healthcare	ASR/Mailhandlers
TriWest, VA, ChampVA, Tricare for Life	Priority Health

All other insurance plans can be reviewed prior to the Initial Appointment for coverage. If the policy is "out of network" any unpaid balance may be the responsibility of the patient or guardian. We do not participate with or file claims with insurance companies located outside the United States.

Work Comp and/or Auto Claims:

Valid workers compensation or Auto information is required prior to or at the time of your first appointment; this information should include the Agency name address and phone number, case worker name and number and claim number. Failure to provide complete billing information, will result in a transfer of responsibility to the patient.

Billing Policy:

OrthoSport Physical Therapy & Athletic Rehabilitation bills your insurance company as a courtesy to you.

If claims are denied due to incorrect insurance information provided by the patient/guardian and/or the policy is inactive; the balance will become the patients/guardian's responsibility.

Co-Pays are due at the time of visit. Co-insurance and deductibles are due upon receipt of your statement. Payment arrangements may be made if requested. Any unpaid or unresolved balances on your account beyond 90 days of your last treatment date or failure to contact us to make payment arrangements will place your account into a delinquent status.

Consent:

I consent to the information stated and I DO specifically consent to receive telephone calls, short messages service ("SMS") text messages, or other messages made or delivered to the telephone number(s) I have provided to OrthoSport Physical Therapy and Athletic Rehabilitation. I acknowledge that these calls may be made or delivered using an automatic dialing system and /or an artificial or pre-recorded voice, made by this clinic or its business associates for purposes of treatment, payment, and health care operations.

____________________________________ _______________________

Signature Date

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Print Name