



623 Hwy 71 West Suite 100
Bastrop, TX 78602
(512) 321-9659
Fax (512) 321-1226

FINANCIAL POLICY

We, the staff of **Garner & Riley Physical Therapy** thank you for choosing us as your physical therapy provider. We believe your understanding of our patients' financial responsibility is vital to the provider-patient relationship. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities, please feel free to contact Connie Wallace at (512) 321- 9659.

We are contractually obliged to collect copayments, coinsurance, and deductibles at the time of service. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service.

We accept cash, credit cards, money orders, and in-state checks. A **\$35.00** service fee will be charged for all returned checks.

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We expect patients to be interactive and responsible for communication with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information, and to notify our office of any information changes when they occur. A pre authorization of services does not guarantee payment from your insurance carrier. We require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. **Failure to provide all required information may necessitate patient payment for all charges.**

Missed Appointments

We require a notice of **cancellations 24 hours in advance.** If you fail to keep your scheduled appointment or fail to give us **24-hour** notice, a missed appointment fee will apply. These fees are **\$50.** If you fail to keep your Initial Evaluation appointment, a **\$100** missed appointment fee will apply.

Timeliness of Appointments

Please arrive on time for your appointments. If you are more than **15 minutes late,** we will have to reschedule your appointment. We try to see everyone in a timely manner but if you are not seen 10 minutes after your scheduled appointment time, please let the receptionist know.



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ASSIGNMENT OF BENEFITS

I understand that services rendered to me by **Garner & Riley Physical Therapy** are my financial responsibility and that the provider will bill my insurance company, as a courtesy. I authorize my insurance company to pay my benefits directly to **Garner & Riley Physical Therapy** and I understand that I will be fully responsible for any outstanding balance on my account. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my insurance company.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to **Garner & Riley Physical Therapy** within 48 hours. I agree that if I fail to send the payment to **Garner & Riley Physical Therapy** and they are forced to proceed with the collections process I will be responsible for any cost incurred by the office to retrieve their monies. In the event I receive any check, draft, or other payment subject to this agreement, I will immediately deliver said check, draft, or payment to the provider. Any violations of this agreement will, at the provider's election, termination patient charge privileges with provider and bring any balance owed by the patient immediately due and payable.



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FINANCIAL POLICY

I have read and acknowledge the information provided in the **financial policy**. I understand that I will be charged a fee of **\$50** or be discharged from services following failed appointments. I understand that a **\$50** fee will apply should I fail to give **24-hour** notice when cancelling an appointment. In addition, a **\$100** fee will apply for a failed initial evaluation appointment.

Signature

Date

ASSIGNMENT OF BENEFITS

I have read and acknowledge the information provided in the **assignments of benefits**. I understand that Garner & Riley Physical Therapy will bill my insurance company as a courtesy, but I am fully responsible for any outstanding balances. I understand that it is my responsibility to notify Garner & Riley Physical Therapy of any changes in my insurance as soon as possible. I also understand that all payments for co-pay, deductible, and co insurances are due at the time of service.

Signature

Date

APPOINTMENT REMINDERS

I give Garner & Riley Physical Therapy permission to use the information I have provided them to send me automated appointment reminders via text or email.

Signature

Date

PERMISSION TO LEAVE A MESSAGE

I give Garner & Riley Physical Therapy permission to leave a voice message for me regarding any patient information and appointments.

Signature

Date



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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize release of my Medical Records to Garner & Riley Physical Therapy, including test results, radiology studies, films, and records received from other health care providers to be used in my treatment and continuing medical care.

Signature

Date

Patient Information:

Full Name: _____

Date of Birth: _____

Address: _____

Insurance Company: _____