

**ANDO & ASTON PHYSICAL THERAPY
FINANCIAL POLICY STATEMENT**

PATIENT NAME: _____

PAYMENT POLICY

1. All Co-payments, Co-insurance and Deductibles are due at the time of service for all patients.
2. If you are the guarantor for a minor's account please make arrangements with our Front Desk Personnel regarding payment for services.
3. Forms of Payment: Cash, Check, Debit Card, Visa, American Express, Discover or MasterCard.
4. Returned checks: A **\$25.00** service fee for the processing of returned checks will be applied to the patient responsibility side of your account.
5. Services may be discontinued until payment issues are fully resolved. If on-going treatment is required, the patient will be referred out to another provider.

INSURANCE BENEFITS POLICY:

1. Ando & Aston will bill your primary and secondary insurance carriers as a courtesy to you. However, patients who have health care insurance should understand that charges for professional services are charged to the patient and not to the insurance company. **You are ultimately responsible for payment for all services rendered**, unless otherwise provided by law.
2. To enable us to provide this service for you, you must:
 - a. Provide us with necessary and correct insurance information for billing to be done correctly and timely.
 - b. Notify us if any part of your insurance coverage information changes during the course of treatment.
 - c. If you elect not to provide all necessary information for billing your insurance company you will be treated as a cash patient and will receive a 'superbill' that you may use to submit your bills directly to your payer for reimbursement.
3. You agree to pay for all charges that are **not covered** by your insurance plans. This includes any service:
 - a. Not described as a covered benefit in your insurance payer's Evidence of Coverage.
 - b. Determined upon review to be "Not Covered", "Not Medically Necessary", "Not Authorized", "Patient Share", "Patient Responsibility" or otherwise deemed a non-payable benefit.
 - c. Including, but not limited to, manual therapy, passive modalities (such as ice, heat, electric stimulation, ultrasound), taping, exercise, and/or neuromuscular reeducation.
 - d. Any service for which your payer changes the number of units of service from that which was actually delivered and billed by us to some other quantity. (Example: changing the units delivered from a '2' to a '1').
 - e. Additional services and supplies you have received.
 - f. You agree to pay our standard charges for non-covered services as described above, and not the contracted insurance rate.
4. If charges billed to your insurance company on your behalf are not paid by your insurance company within a reasonable time (as defined by Section 1371 of the Knox-Keene Act) the overdue amount will become your full responsibility and payment will be due at that time. It

will then become your responsibility to resolve the outstanding issue with your insurance company and receive your reimbursement from them.

- a. Note: Most insurance companies pay within 3-4 weeks.
- b. You can help facilitate payment on your account by reviewing your Explanation of Benefits (EOB) and responding to any requests in a timely manner. Please notify us immediately if payment is denied.

PATIENT BILLING PROCESS:

We will make every attempt to process all of your claims in a correct, efficient, and timely manner.

1. Once your insurance company begins making payment on your account you will receive two statements per month to inform you of your account status.
2. Any outstanding balance on your statement is due within 10 days. All bills are due and payable upon presentation. If more than two statements are sent for any given date of service the third and subsequent statements will be subject to a **\$10.00 rebilling fee**.
3. If you do not receive an EOB from your insurance company or a statement from us within 45 days contact us immediately so that we may help you determine if there is a problem with your claim.
4. If you do not make payment within the above time frames, we will make three attempts to resolve any problems or concerns that may exist:
 - a. Courtesy Reminder Notice
 - b. Second Request to Pay letter
 - c. 5-day Demand for Payment Notice
5. Unresolved financial disputes for non-payment of fees for services rendered will result in discontinuation of services, referral to another provider as necessary and possible assignment of the collection responsibility for this account to a professional Collection Agency or presentation to Small Claims Court for a judgment in the amount due **plus** filing fees, court costs and interest. If a judgment is issued, or if you are sent to a professional collection agency, it will be recorded on your credit record.
6. Ando & Aston reserves the right to charge interest at the legal prevailing rate (up to a maximum of **10%** per annum) and to apply late payments or service fees for multiple payment plans as necessary to manage the collection of your account.

REFUNDS:

Overpayments will be refunded upon written request to the responsible party within 30 days.

ASSISTANCE:

Ando & Aston has a full-time Account Representative to assist you with any questions you may have regarding your account. Our Account Representative is available Monday through Thursday, 8 AM to 5 PM, and Friday 8 AM until Noon to assist you at 714-974-0330 extension 21.

AUTO ACCIDENT

You must notify our Front Desk Personnel if your reason for treatment is due to an automobile accident prior to beginning treatment.

LIENS/ AND/OR PERSONAL INJURY:

Ando & Aston does not accept liens. We can not wait for settlements of a pending lawsuit for the payment of services provided. We can not deal with your attorney, or other legal representatives for settlement.

ACCEPTANCE OF FINANCIAL POLICY:

1. I have read and understand the financial policy of Ando & Aston Physical Therapy.
2. I agree to assign insurance benefits to Ando & Aston Physical Therapy whenever necessary.
3. I agree to pay any and all balances due and understand that Ando & Aston will not hold accounts for payment.
4. I understand that if I do not pay my account as designated, my debt may be presented in Small Claims Court for judgment, or sent to a professional collection agency.

Name of Patient: _____ **Date:** _____

Signature of Insured or Guarantor: _____

Ando & Aston Reviewer: _____