

# Boulet Physical Therapy & Wellness Institute

Relieving your pain • Restoring your movement

## FINANCIAL POLICY AND PROCEDURES

*We are committed to providing you with the best possible care. If you have health insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.*

*Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, Visa or Discover. We will be happy to file your insurance claim-form for you for insurance reimbursement.*

*Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1 ½% per month. We require a 24-hour cancellation notice if you are unable to keep your scheduled appointment. If you fail to cancel your appointment within 24 hours of your scheduled time we will collect a \$25.00 fee prior to you receiving any additional physical therapy treatment.*

*We will turn your account over to a collection agency if your bill is not paid in full within 90 days of your discharge date.*

*If an attorney is representing you, you will pay for depositions, court testimonies, attorney meetings and any and all legal matters in the event your attorney fails to make payment.*

*I have received a copy and fully understand Boulet Physical Therapy and Wellness Institute's Financial Policy and Notice of Patient Information Practices. I understand that BPTWI may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed. I understand that I retain the right to revoke this consent if I notify BPTWI in writing. I also understand that BPTWI will consider request for restriction on a case-by-case basis, but does not have to agree to the request for restrictions.*

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*Patient Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Reviewed By*  
*Financial policy and procedures*

\_\_\_\_\_  
*Date*