TUALATIN VALLEY
PHYSICAL THERAPY
Care, when you need it

333 S 1st Ave.
Hillsboro, OR, 97123
(971) 238-5755
www.tv-pt.com

Payment and Insurance Policy

FINANCIAL POLICY

It is our policy in this office to maintain your account on a current basis. Please advise our clinic of any changes or updates in address, insurance, phone, new injury or employment changes to ensure accurate billing. Charges for treatment are due on the day the service is provided, unless we are preferred providers of your insurance plan. We accept cash, checks, Visa, American Express, and Mastercard. A fee of $35 will be charged for all returned checks. For insurance, we ask that you make all applicable copayments at the time of each visit. Your remaining balance must be paid in full within 30 days of your invoice, and any unpaid balance will be considered past due. Tualatin Valley Physical Therapy, LLC reserves the right to set up a payment plan for balances on an individual basis. Payment plans must be in place before the balance is due. Once a balance is past due, we reserve the right to start charging interest, send to collections, and/or take legal action.

PATIENT'S RESPONSIBILITY

It is the patient's responsibility to pay for any balances due in a timely manner for services rendered, regardless of insurance claims status. _____ (Initial)

It is the patient's responsibility to:

- Understand their insurance policy, and to ask questions when they don't.
- Obtain a referral indicating medical necessity for physical therapy services, when applicable.
- Pay co-pays at time of service.
- Promptly pay any patient responsibility (coinsurance/deductible) indicated by their insurance carrier.
- Contact their insurance carrier when claims have not been paid.
- Obtain updated referrals or prescription for physical therapy when there has been more than a 30-day lapse in care or when their referral is dated more than 30 days previous to their 1st visit, if applicable.

INSURANCE PATIENTS

I hereby authorize Tualatin Valley Physical Therapy, LLC to furnish information to my insurance carrier(s) concerning this treatment and I hereby assign all payment for services rendered to Tualatin Valley Physical Therapy, LLC. _____ (Initial)

I understand that the benefits quoted to me are not a guarantee of claim payment. I understand that payment is dependent on my eligibility at the time of service and ALL terms and conditions of my insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. _____ (Initial)

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MEDICARE PATIENTS – (please provide card)
Have you had any PT this year provided in your home or in another outpatient clinic?

- ☐ Yes, _____# of visits
- ☐ No

Do you currently have Medicare home services?

- ☐ Yes
- ☐ No

Medicare ID: _____

WORKERS COMPENSATION CLAIMS
Please provide the office the name and phone number of your claims representative before you begin treatment. We request your private insurance information at the time of service. If your claim is not accepted we will bill your private insurance. You are responsible for payment of services rendered if your claim is not accepted. _____ (Initial)

Case manager's contact info: _____
Claim #: _____

MOTOR VEHICLE ACCIDENTS
We will bill your Personal Injury Protection Insurance (PIP) as a courtesy to you. However, you are fully responsible for the bill. In the event that payment has not been made within 30 days, you will be required to make payment arrangements. _____ (Initial)

SELF PAY PATIENTS
For patients without insurance or with insurance we are not contracted with, we offer self-pay rates which must be paid on the day of service. _____ (Initial)

VOLUNTARY TERMINATION OF TREATMENT
It is also the policy of this office that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable. _____ (Initial)

I have read the above information and **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

Patient or Guardian Signature: _____

Date: _____