VPTR - BILLING POLICY

COMMERCIAL INSURANCES

Vantage Physical Therapy is a participating provider with most insurance carriers. As a courtesy, we are able to help assist you in verifying coverage of services provided by our office. However, this is not a guarantee of payment. You are responsible for any deductible, co-insurance, or copay that applies to your specific policy.

MEDICARE

Vantage Physical Therapy is a participating provider with Medicare. This means we will accept the Medicare "allowance" for covered services. You are responsible for any outstanding deductibles and/or the 20% co-insurance either directly or through supplemental insurance coverage.

> I certify the information required for payment under Title XVIII of the Social Security Act is accurate. I request payment of authorized Medicare claims directly to **VPTR** on my behalf for the starting period of services until discontinuation of services.
>
> **Patient Signature**____ **Date** _______________

****COPY OF PRIVATE INSURANCE IS REQUIRED WITH ALL WORK COMP AND AUTO CLAIMS****

PA WORKMEN'S COMPENSATION

Please provide detailed billing information including name, address, phone number, and claim number. Your charges will be billed according to the 1993 Act 44 Workman's Compensation Law. Workmen's compensation claims not paid within 60 days or denied will be submitted to your private carrier. Otherwise, the unpaid balance will be your responsibility.

AUTO ACCIDENTS

Please provide detailed billing information including name, phone number, address, claim number, and name of adjuster of the Insurance Carrier. Your charges will be billed according to Act 6 of the 1991 PA Motor Vehicle Financial Responsibility Law. Auto insurance injuries, which have reached the maximum benefit or are found to be unrelated to the accident, will be submitted to your private carrier. Any unpaid balance will be your responsibility.

NO INSURANCE

If you do not have insurance that covers your physical therapy treatments, you will be billed monthly and responsible for payment of the bill. Monthly payments are expected on your account.

IN THE EVENT OF DELINQUENT PAYMENTS:
Your account will be turned over to a collection agency and a collection fee of $25 will be added to your account.

If at any time you have any questions or concerns regarding your bill, please feel free to ask.

I certify that my insurance carrier(s) have a contract with me to cover the fee for service (excluding deductibles and co-payments, if applicable). If the insurance company should refuse payment, I am responsible for the entire fee for service. Any monies received by me from insurance companies, intermediaries, etc. for such services will be immediately given/signed over to **VPTR**.

Patient's Signature ____ **Date** _______________

(Signature signifies that you have read and understand the above)