Bristol Physical Therapy, LLC

466 East St, Plainville, CT 06062 • Phone: (860) 589-0444 • Fax: (860) 314-1588
www.BristolPhysicalTherapyLLC.com

PROCESS SERVICE CHARGE/ CANCELLATIONS / NO-SHOWS / PAYMENT RESPONSIBILITY

We are committed to providing you, our valued patients, with excellent quality and convenient physical therapy services. We reserve time in our schedule specifically for you. Toward that end, we ask your cooperation by making every effort to keep scheduled appointments. If you cancel last minute, or no-show, then you are affecting other patients who may be waiting for an appointment. Unfortunately, due to increased administrative costs (office rent, utilities, liability insurances, reimbursement processing, etc) and decreased reimbursement for services, we are have instituted an administrative service charge beginning May 1, 2018 in order for us to continue giving you high-quality one-on-one care.

WE ASK YOU TO GIVE AT LEAST 24 HOURS NOTICE FOR AN APPOINTMENT CANCELLATION.
Fees (not covered by health insurance) are as follows:

- **Administrative service charge $5.00/visit**
- **Cancellations with less than 24 hours notice: $40 per instance**
- **No-show physical therapy appointment: $85 per instance**
- ***LATE AND NO-SHOW FEES MUST BE PAID PRIOR TO ANY FUTURE VISITS***
- **Private pay (out of pocket) $85/visit; $80/ 5 pre-paid visits; $75/10 prepaid; initial eval subject to higher rate**
- **Orthotic fitting - $25 (no charge if during either insurance-covered or private pay visit) + cost of orthotic**

Due to constant changes with health care insurance, it is each patient's responsibility to know how their insurance works in terms of coverage.

ALSO, PLEASE LET US KNOW IF YOUR INSURANCE HAS CHANGED, SO WE CAN BILL THE CORRECT INSURANCE COMPANY IN A TIMELY MANNER.

PATIENTS ARE RESPONSIBLE FOR ALL CHARGES, REGARDLESS OF INSURANCE.

CO-PAY IS DUE AT TIME OF SERVICE.

In some cases, we will need to bill your insurance in order to know exactly what your out-of-pocket expense will be. When this occurs, we will collect an estimated amount to cover co-pay, co-insurance and/or deductible until the insurance company returns the first EOB (explanation of benefits). If you have an unmet deductible, full payment is expected at each visit.

I understand it is my responsibility to check with my insurance company to verify what my policy covers. It is my responsibility to pay deductible, co-pay and co-insurance.

Patient name (printed) _____

Patient Signature _____ Date _____

Parent/Guardian _____ Date _____