Active Balance
Physical Therapy, LLC

1100 Main St *Po Box 1064*Dayton, WY 82836
Phone (307)655-2509 Fax (307)655-2275

PAYMENT POLICY

1. **Billing Insurance:** It will be our pleasure to bill your insurance company for you, provided that you submit accurate billing information.
2. **Co-Pays:** Co-Pays are expected at the time of services, no exceptions. It is your contractual agreement with your insurance to pay your co-pay at the time of service.
3. **Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you with the payment expected within 30 days.
4. **Nonpayment:** If your account is over 60 days past due, we will expect payment in full before further treatment is provided by our facility. Understand that you will be charged a late fee of $10.00 a month for accounts that are past due. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. You will be responsible for any collection fee incurred and you and your immediate family members may be discharged from this practice.
5. **Missed Appointments:** Please notify us of a canceled appointment by 5:00 PM of the prior day. Our policy is to charge up to $100.00 fee for missed appointments. These charges will be your responsibilities and billed directly to you.
6. **Payments:** If you are currently without insurance coverage, we offer a discount for payment in full at the time of service. We accept payments by cash, check, or credit card.
7. **Medicare:** Medicare has a new ruling for private practice physical therapy offices: you must be seen by your doctor prior to starting therapy and the prescription is good for 30 days from the first day you start your therapy. After the 30 days have expired Medicare requires that we send your physician an updated treatment plan to continue your physical therapy. Medicare does not cover 100% of physical therapy and I understand that I am responsible for the remainder of the balance.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY FOR ALL CHARGES, REGARDLESS OF INSURANCE OR OTHER THIRD PARTY COVERAGE.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES:

SIGNATURE:_____**DATE:**_____