



5950 Santo Road, Suite D, San Diego, CA 92124 • 858/715-3878 • Fax 858/715-3879

FINANCIAL AGREEMENT

Your doctor has prescribed physical therapy for you. Physical therapy is often an ongoing process that requires regular attendance to be effective. We encourage you to follow all orders by your doctor.

We are committed to providing you with the best possible care. In order to help you achieve your maximum allowable benefits from your medical insurance, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time of service unless payment arrangements are approved in advance by our staff. We accept cash, checks, MasterCard and Visa. We will be happy to help you process your insurance claim form for your reimbursement. If you would like us to bill your insurance we must have an assignment of benefits; we will collect your deductible and copayments weekly.

If you would like to bill your own insurance, payment will be due at the time of service, and a receipt will be furnished so that you may file for your own reimbursement. If you are covered by Workman's Compensation Insurance, be advised that you may be held responsible for your charges in the event your claim is controverted.

PLEASE READ AND SIGN THE FOLLOWING STATEMENT

I understand that my insurance is a contract between me, my insurance company and/or my employer. Adjust Physical Therapy is not part of that contract. (Please be advised, if for any reason, your insurance company pays less than the percentage stated in your contract, you are responsible for the difference).

If any payments are made directly to me for services billed by Adjust Physical Therapy, I understand I am obligated to promptly remit the same to Adjust Physical Therapy with a copy of the Insurance Explanation of Benefits.

I understand and agree that if I fail to make any payments for which I am responsible in a timely manner, I will also be responsible for all costs of collecting monies owed, including court costs. I realize that returned checks are subject to a \$10 fee in addition to the immediate cash payment for services rendered.

I agree to give 24 hours advanced notice if I am unable to make my scheduled appointment, or there will be a \$35.00 charge due on my next appointment (unless you are covered by Workman's Compensation, Medicare and MediCal).

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF MY ACCOUNT.

I UNDERSTAND THAT I AM TO PAY ANY DEDUCTIBLE, COPAYMENT OR OTHER CHARGES NOT COVERED UNDER MY INSURANCE.

Signed: _____ Date: _____ Witness: _____