



PHYSICAL THERAPY AND SPORTS MEDICINE CENTER
9340 Fuerte Drive, Suite 303A
La Mesa, CA 91941

Welcome to our practice and thank you for choosing us as your health care provider. In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy.

I, the undersigned, understand and agree that the professional services rendered to me (or to the minor child for whom I am responsible) by Physical Therapy and Sports Medicine Center (hereafter known as "the Center") are my sole financial responsibility. I further understand that my insurance policy is a contract between me and my insurance company and that the Center may bill my insurance as a service to me, but that I am ultimately responsible for payment for any services or supplies I receive. Any denial of payment or dispute between myself, the Center and/or any third party does not relieve me of my financial responsibility to the Center.

Full payment or accurate insurance information is due at the time of service. The Center may require that any portion of my bill that is not covered by my insurance carrier, including deductibles, co-payments and any non-covered items or services, be paid at the time of service or on a weekly basis. Accounts are due in full ten (10) days after receipt of a billing statement and are delinquent after thirty (30) days. If payment from any source is not received by the Center within sixty (60) days of billing, I understand that I may be expected to pay the total balance of my bill in full. A service charge of one percent (1%) per month will be added to any unpaid balance. I understand it is my responsibility and not that of the Center to refile lost claims or to resolve disputed insurance coverage.

A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

In the event that it is necessary to retain an attorney to collect my unpaid account balance, I agree to pay reasonable attorney's fees and any other collection expenses.

I agree to provide the Center with a copy of my current insurance card and will inform the Center within 30 days of any changes in my personal address, telephone number or insurance coverage.

If I am unable to keep any appointment that I have scheduled or has been scheduled for me, I understand I must give 24 hours notice of cancellation in order to allow another patient to be scheduled in my place. Failure to do so will result in my being charged at the Center's current cash pay rate for the full time of my appointment, which my insurance may not cover. Failure to show for my appointment on two occasions without 24 hour notice to the Center, may preclude me from scheduling future appointments in advance, although same day appointment scheduling may be allowed.

By my signature below, I certify that I have read and understood the financial policy as outlined in this document and agree to be bound by its terms. I understand that the terms of this agreement may be amended from time to time by the Center.

Signed: _____ Date: _____

NON-PARTICIPATING/NON-COVERED INSURANCE

I understand that the Center is NOT a participating provider with _____.
I agree to assume financial responsibility for any and all charges not covered by the above named insurance for services rendered to my by the Center

Signed: _____ Date: _____