

FINANCIAL POLICY STATEMENT

Southern Nassau Physical Therapy, Western Nassau Physical Therapy and Seaside Physical Therapy/DBA Peak Performance Physical Therapy will bill your insurance carrier as a courtesy to you. Patient responsibility is explained to you and co-payments or other payments responsibilities are due at each visit. Coinsurance and other payments will be billed to you after we receive payment from your insurance company.

It is your responsibility to inform the front desk of any policy changes in your insurance immediately. Many of the insurances require prior authorization for physical therapy. In the event of a policy change it may be required to obtain prior authorization. This is one of the very important reasons for immediate notification of policy change. In the event your insurance company requests a refund for payments made, you are responsible for the amount of money refunded by insurance company. In the event your insurance company reimburses payment directly to your home, payment must be signed over to Peak Performance Physical Therapy. Estimated coverage information is provided to you as a courtesy. It is not intended to release you from any patient responsibilities. We recommend checking your own benefits with your insurance company.

Workers Compensation and No Fault patients: if your case is closed or coverage is no longer effective it is your responsibility to submit a copy of your commercial insurance card to the front desk or the billing department. Check with the front desk or billing department to see if Peak Performance is a participating provider. If you do not have other medical coverage you are responsible for payment of your bills.

In the event payments requested from our office are not received in a timely fashion your account will be forwarded to our collection agency.

CANCELLATION POLICY

This is to notify you that we will charge you a \$15 fee, \$20 for aquatic therapy for all appointments missed within less than a 24 hour notice. Our office does acknowledge extenuating circumstances and will take into consideration when charging the fee.

Signature of patient or patients representative

Date

If this form is signed by the patient's representative, please complete the following:

Print the name of the Patient's Representative: _____

44 Broadway
Lynbrook, NY 11563
516-599-8734

3961 Long Beach Rd.
Island Park, NY 11558
516-897-9700

1730 Lakeville Road
New Hyde Park, NY 11040
516-326-4580