Pinnacle Physical Therapy & Sports Medicine
796 Highway 96, Suite 2B
Bonaire, GA 31005
P: (478) 302-5111
F: 478-225-6453

Financial Policy and Service Contract

PLEASE READ CAREFULLY AND SIGN

It is my responsibility to know the limitations and restrictions of my insurance company regarding physical therapy services . I am responsible for paying my balance regardless of my insurance company's payments. Copays are expected to be paid at the time of service. If my insurance company does not cover my treatment and I choose to pay out of pocket for treatment, my balance is due at the time of my appointment.

The fee charged for an office visit is determined by the level of treatment or complexity, which is not always known at the time of service. Per federal regulation, complexity is determined using a formula that takes into account both chronic and acute issues. Pinnacle Physical Therapy & Sports Medicine will conduct an evaluation to determine the level of complexity.

As a courtesy, Pinnacle Physical Therapy & Sports Medicine will file your insurance claims on your behalf and contact the insurance company/ies before your appointment to verify your insurance benefits. However , we suggest that you contact your insurance company as well before your first visit to verify your physical therapy insurance benefits as well. **Your insurance policy is an agreement between you and the insurance company. It is a contract between YOU and them.** You are ultimately responsible for co-pays, co-insurances, and/or deductibles that apply to your specific insurance plan. If your insurance claim is denied due to lack of coverage or your insurance company will not pay for the services that you have received, you are responsible for the entire balance.

Your portion of the bill must be paid within 30 days of the billing date on the statement.

Certain payment plans are available upon request and you may contact our office at 478-302-5111 and ask to speak to the office manager.

Payment plans are subject to the terms agreed upon in the separate payment plan agreement and must be adhered to. After 60 days, unpaid balances will be considered past due and will be sent to collections.

We accept VISA, MasterCard, Discover, in state checks, and cash.

Patient Signature:_____ Date:____/___/___

Patient Printed Name:_____ Date:____/___/____

Parent or Guardian Signature: _____ Date:____/___/_____

(if under 18)

Parent of Guardian Printed Name:_____ Date:____/___/_____