DESERT EDGE
PHYSICAL THERAPY

Financial Policy

If your visit is related to an automobile or personal injury accident, please notify the front desk.

I understand it is my responsibility to understand my health insurance benefits, verify necessary referrals/authorizations are on file, and pay subsequent out of pocket expenses. I request and authorize my health insurance carrier to pay Desert Edge Physical Therapy for all charges related to services provided to me. I understand that I am entirely financially responsible to Desert Edge Physical Therapy for all services rendered and agree to pay in full any amounts not paid by an insurance company or other third party payer in addition to all co-payments, deductibles, or co-insurance which are due at time of service. All other payments are due 30 days after time of service. Should my account go to collections, I agree to pay all attorneys fees, court costs, filing fees, and all other charges that may be assessed. I further agree to pay interest in the amount of 1.5% per month on any balance over 90 days.

I understand that not showing for scheduled appointments will delay my plan of care, and that if I cannot attend one of my scheduled appointments, I must give a minimum of 24-hour notice when canceling. Failure to do so will result in a $25 fee.

Desert Edge Physical Therapy verifies insurance coverage and obtains a summary of insurance benefits for company purposes only. Although we may provide you with a copy of the benefits we were quoted, you are ultimately responsible for understanding your benefits. When we obtain a quote, we are given the following disclaimer: *This is an estimate of benefits only and in no way guarantees coverage or payment of claims*. If you have questions regarding your coverage, please call your insurance company.

I understand that should my insurance benefits limit my physical therapy to a specific number of visits per year/condition, monetary amount, or require a referral or pre-authorization, it is MY responsibility to keep track of those numbers and verify with the front desk that the appropriate documents are on file. If I happen to go over my benefit limitations or neglect to verify authorizations/referrals are on file, I will be responsible for the entire balance on the exceeding visits or amounts.

I understand that regardless of insurance, I am responsible for the cost of all services rendered at Desert Edge Physical Therapy. Should my insurance company pay my claims at a different rate than was quoted to Desert Edge Physical Therapy and listed above, I will honor the actual assignment of benefits. If I am not satisfied with the actual assignment of benefits, it will be my responsibility to contact my insurance company.

I understand it is my responsibility to know which insurance is my primary carrier and which is my secondary. I recognize that Desert Edge Physical Therapy relies on the information I provide to obtain my benefits information. I verify that I have provided them with the correct info at the time of my visit.

My signature below verifies that I have not joined an HMO or other entity in which my Medicare/all other insurance benefits have been relinquished.

Patient/Legal Guardian Signature _____ Date _____