To provide the best possible care and most effective treatments, this is the financial policy of Freedom Physical Therapy Services. This document is an agreement between Freedom Physical Therapy Services (FPTS) and the Patient/Responsible Party signed on this form. By executing this agreement, you are responsible for all medical bills and other charges that result from services rendered by FPTS.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the provider and is not a substitute for payment. Regardless of insurance coverage, you are responsible for all balances incurred. Some insurance companies may pay fixed allowances for certain procedures, sometimes referring to these as "Reasonable and Customary Fees." We do not accept this as payment in full, unless otherwise restricted by law or the contract agreement we may have with your insurance carrier(s). Many insurance companies pay only a percentage of the charge, leaving it your responsibility to pay any deductible amount, co-insurance amount, co-pays (due at each visit) and any other balance not covered by your insurance carrier(s). As a courtesy, our office may inform you of the benefits we were quoted by your insurance carrier(s); however, this is not a guarantee of your actual benefit plan or payment. If you have any further questions, please contact your insurance carrier(s). _____ (Initials)

DEDUCTIBLE:

If you have a plan with a high deductible (FPTS is classifying this as anything at $1000 or higher) which has not been met, we will estimate the deductible amounts based on what we have been led to expect your insurance company will pay. Please note that any payment made on the date of service is considered a DEPOSIT toward your ESTIMATED patient balance. Because this is an estimate, there is always the possibility that you may be either responsible for an additional balance or due a refund. If a refund is due – it will be promptly provided. If it turns out that your insurance company payment is less than expected – you are responsible to promptly pay any additional balance due. An unpaid balance over 30 days will start to incur an interest rate of 1% per month. _____ (Initials)

If you have a high deductible plan and have not met your deductible, we will be collecting $100 until your deductible has been met. You are required to make this payment to be seen for your appointment._____ (Initials)

Please be aware the Initial Evaluation/Visit usually costs more than subsequent visits due to the Evaluation and documentation required by your carrier. In addition, there are times where we need to get authorization for additional visits, which again triggers another Re-Evaluation or Progress note and consequently these visits can also be more than subsequent visits. _____ (Initials)

FREEDOM
PHYSICAL THERAPY SERVICES, S.C.

Patient Insurance Verification:

We do our absolute best at FPTS to verify your Health Insurance to determine your proper copay, co-insurance / deductible / visit limit and if your plan is in or out of network. We cannot, however, be responsible if your plan pays differently than what we were told. You should call your insurance to verify what your benefits will be for Therapy at our practice and location. We will also bill to your secondary insurance as a courtesy and if there is any balance due, you will be held accountable.

In the event you are scheduled for an appointment before we have had a chance to call on your benefits, please remember you are responsible for knowing your coverage. _____ (Initials)

Workers Compensation, Accidental Injuries, Liabilities:

If you are claiming workers compensation or filing claims to a liability carrier, you must provide us with a copy of your primary insurance card and a physician's referral. For workers compensation cases, we must have prior authorization from your employer to begin treatment. For liability cases, you must sign all forms relating to your case. The attorney handling your case must sign our lien form. In the event payment for your claim is denied by a worker's compensation or liability carrier, we will file claims with your personal health insurance. If your claim is denied by your personal health insurance, you will be required to pay any balance due to Freedom. In the case of personal injury, you instruct and authorize your attorney to pay directly to Freedom Physical Therapy Services, any monies due on your account. You agree that, in the event of a settlement, the payment to Freedom Physical Therapy will occur directly from the trust account held by your attorney before any monies are distributed directly to you. If you do not receive a settlement or it is less than your total bill, you will personally be responsible for the balance and/or cost for all services rendered. Any balances owed by you will be subject to Freedom's interest charges for patient balances. _____ (Initials)

Minor Patients:

A parent or legal guardian must accompany minors at the time of their initial visit. The parent or guardian is responsible for full payment. If parents are separated and both are legally responsible for the treatment of their minor child, please provide complete information from both parents/guardians so we may bill the appropriate insurance. For unaccompanied minors that are required to pay a co-pay at follow up appointments, a pre-authorized credit card must be used as a result we will keep your keep your credit card on file to process estimated payment, copay, Coinsurance, at time of visit, or cash/check at the time the service will be required. _____ (Initials)

Missed Appointments/Cancellation/No Show

Unless cancelled at least 24 hours in advance by telephone, your account will be charged $75.00 for each missed appointment. This also includes if you do not show to

your appointment. This fee must be paid before a new appointment can be scheduled. _____ (Initials)

Treatment:

You hereby consent to the rendering of a physical and occupational therapy evaluation and treatment as deemed appropriate by the treating therapist. You have the right to decline treatment at any time. Your therapist will explain your therapy diagnosis and discuss treatment recommendations with you. We strive to provide the highest quality care with minimal discomfort; however, some conditions are painful to treat. Therapy is most effective if you participate according to the plan of treatment agreed upon with your therapist.

Supplies: During the course of treatment, there may be supplies that will be beneficial to your treatment. These are sold on a cash basis and not billed to your insurance. Pricing will vary by item. _____(Initials)

Past Due Accounts:

An account becomes past due 30 days after it becomes patient responsibility. Your balance will be communicated by statement every month. If your account becomes past due, we will take the necessary steps in contacting you to collect this debt. If these attempts do not generate a response from you, your account WILL be subject to the following fees: Finance Charges (currently 1.0% per month) , In House Collection Fees, Collection Agency fees and any Attorney fees. _____ (Initials)

Returned Checks:

If your check is returned, your account will be charged an administrative fee plus any associated charges assessed to us by our bank for the handling of the returned item. _____ (Initials)

Self-Pay Accounts:

If you do not have health insurance, we do offer self-pay plans. Self-Pay payments are due at the time of service and are non-refundable. Packages expire 12 months after date of purchase.

Please speak to our Clinical Director or Billing Manager for more information. If you are unable to provide us with your health insurance, worker's compensation insurance or personal injury insurance within 48 hours of your first visit, you may be turned over to a self-pay account status. Even if you provide us with your insurance information after the initial 48-hour period we reserve the right to refuse to bill your insurance. ____ (Initials)

FREEDOM
PHYSICAL THERAPY SERVICES, S.C.

Medical Records Release:

You authorize Freedom Physical Therapy to release any information pertinent to your case to any doctor, insurance company, adjuster, or attorney involved in your case or to anyone you designate in writing as able to receive your medical information. ____ (Initials)

Communication Preferences:

I consent and state my preference to have Freedom Physical Therapy communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, treatment, appointments, and billing. I understand that email and standard SMS messaging are not confidential methods of communication and may be unsecure and that there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party. ____ (Initials)

Privacy Practices:

You have been offered the opportunity to review and to receive a copy of Freedom Physical Therapy's Notice of Privacy Practices with an effective date of September 2017. You recognize that for the purposes of treatment, payment, healthcare operations or as permitted or required by law, you give your written authorization to Freedom to release any of your protected healthcare information. ____ (Initials)

As part of an insurance contract, Freedom is participating in WISHIN. WISHIN is a database that gathers health information to connect physicians, clinics, hospitals, pharmacies, and clinical laboratories. The objective is to share your personal health information with other health care professionals who may be treating you. All participating professionals in WISHIN have access to all patient information in the database. However, each professional must state that they will only review information for patients they are treating. The health care professionals are currently in Wisconsin, Illinois, Minnesota, and Iowa. At Freedom, we believe it is important for you to be aware of who has access to your personal health information.

In accordance with Wisconsin law, you are automatically enrolled in WISHIN. If you do not wish for your personal health information to be shared in this database, you can opt out. If you opt out, only emergency room physicians can still view your information. The link to opt out is: https://www.wishin.org/Portals/0/Policy/Patient%20Choice%20Form.pdf

If you would like to review additional information about WISHIN, please go to wishin.org

FREEDOM
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CARD-ON-FILE PROCESS

You will be required to provide a credit card when you check in for your visit. The information will be held securely until your insurance has paid their share and notified us of any additional amount owed by you. Any outstanding balance on your patient statement will be charged to your credit card. You may call our office if you have a question about your balance. ____ (Initials)

Monthly Statement:

If you have a balance on your account, we will send you a monthly statement. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable on or before the due date specified in the statement and is past due if not paid on or before that date. We do charge interest (1.0% per month) on all past due accounts; interest will begin accruing once the account becomes 30 days past due. ____ (Initials)

We accept payment by cash, check, VISA, and MasterCard.

My signing below indicates that I have read, understood, and agree to abide by FPTS's Financial Policy and agree to all the terms and conditions contained herein and acknowledge that the agreement will be in full effect. (If patient is under 18 years old, Parent/Guardian must sign where indicated below.)

Patient Signature: _____Date: _____

Print Patient Name:

_____

Responsible Party (if patient is a minor):

_____

(Rev. 12-29-24)