BIG SKY PHYSICAL THERAPY INC. PAYMENT AND BILLING POLICIES

Your insurance contract is between you and your carrier. If your insurance has not paid for covered services within 60 days of the service, you will need to make full payment to this office and be reimbursed when the insurance pays. If you have questions or concerns about your insurance coverage, please call your carrier. It is the responsibility of each patient or their legal guardian to understand the terms and conditions of their insurance plan(s).

Health Insurance Claims:
We will submit claims on your behalf to your primary and secondary insurance carriers. When insurance information is unavailable or invalid insurance is provided at the time of service, the patient or their legal guardian is responsible for all charges incurred. Patients or their legal guardian are required to bring a photo ID, their current insurance identification card(s) and the applicable co-payment to each appointment.

Medicare Claims:
Big Sky Physical Therapy accepts Medicare Assignment. We will submit your claim directly to Medicare and will bill your secondary insurance after Medicare has paid their portion. You are responsible for any allowed amount that is not paid by Medicare and/or your secondary insurance

Motor Vehicle or Other Liability Claims:
Big Sky Physical Therapy will submit claims to your Motor Vehicle or other Liability Insurance Carrier, if you provide accurate and complete billing information at the time of your initial visit. We will verify your claim information, as well as the availability of Personal Injury Protection coverage (PIP) on your claim. If your PIP has been exhausted or expired, we will bill your private medical insurance coverage on your behalf. If you do not have a Liability Insurance Carrier, do not provide us with correct and accurate information, or do not have private medical insurance you will be expected to pay for treatment at the time of service.

In the event that your claim is disputed or a suit is established against another party, Big Sky Physical Therapy Inc. cannot accept the responsibility for collecting or negotiating settlements. Patients will be asked to work with our Business Office to establish a suitable payment plan for your medical charges, as well as to sign a Lien Agreement. While we understand that settlement of these cases can take months; claims against another party are not a reason for non–payment of the medical services you have received.

Big Sky Physical Therapy Inc. Business Office bills your health insurance plan within a few days of your visit. Health plans usually pay within 30 days. Occasionally, a health plan may request additional information before paying a claim resulting in more than 30 days. After your health insurance carrier has processed your claim, you will receive a patient statement from us for the remaining patient balance (for example, coinsurance or deductible). Your balance is due upon receipt of your statement.

Responsibility for Accounts
It is important that you communicate with your health insurance carrier when they send you an inquiry or a dispute arises. Claims payment and/or non-payment disputes with your health insurance carrier are your responsibility to resolve. A NSF charge of $25.00 will be applied to all returned checks.

Parents or other legal guardians, who accompany child and/or complete paperwork, are considered the account guarantor and as such are responsible for payment for minor children. Big Sky Physical Therapy Inc. is not responsible for managing divorce decrees or other legal matters pertaining to payment responsibility

Payment Arrangements
Payment in full is due upon receipt of statement. If you are unable to do so, a scheduled payment plan must be arranged. Please call our office at 503-883-8646 to make payment arrangements. Failure to meet your financial responsibility may result in collection or legal action. Accounts that are more than 60 days past due may be turned over to a collection agency and will be assessed a $15 processing fee.

	Authorization for Treatment ➢ I hereby give authorization for the performance of such rehabilitation procedures as permitted by Oregon Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.
	Authorization for Release of Information ➢ I agree that Big Sky Physical Therapy Inc. may provide information from my medical record to persons involved in my medical care. ➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Big Sky Physical Therapy Inc. for services rendered. ➢ I agree that Big Sky Physical Therapy Inc. may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ➢ I have read "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment ➢ I authorize that direct payment of any benefits available to me be released to Big Sky Physical Therapy Inc. for services rendered.
	Patient Agreement ➢ I agree to Big Sky Physical Therapy Inc. charges for services rendered to me during my course of treatment. ➢ I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Big Sky Physical Therapy Inc. collections costs including attorney and court fees.
	Medicare, Medicaid, and Similar Benefits ➢ I agree that the information given to Big Sky Physical Therapy Inc. in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that Big Sky Physical Therapy Inc. may give Social Security Administration or its fiscal intermediary's information necessary to process claims. Workers Compensation
	Workers Compensation ➢ I agree that the information given to Big Sky Physical Therapy Inc. in applying for benefits under Workers Compensation is complete and accurate. I agree that Big Sky Physical Therapy Inc. may give intermediary's information necessary to process claims.

NO SHOW POLICY – I understand that 24 hour notice is required for cancellation of an appointment. If I no show/cancel in less than 24 hours a $40 charge will be applied to my account. **(NOTE: IF WORK COMP OR MVA, this will not be billed to your insurance, but your personal account.)**

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Patient / Guardian or Legal Representative Signature

Date

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Printed Patient / Guardian Name Date