Special K Fitness

3180 N Butler Ave Bldg. 300A
Farmington, NM 87401

P. T.

Phone: (505) 326-2460
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# Patient and Financial Policy

Patient Name:_____
Date:_____

Copay/Coinsurance (Per Visit)*_____ Deductible Amt not met_____

*If % then payment goes toward that % with remainder to be billed or refunded after all dates of services have been posted.

☐ Your deductible has not been met. By signing this form, you agree to make payments of $75 at each visit until the deductible is met. If you have a copay or coinsurance, we will continue collecting $75 each visit until you are caught up.
**You may still owe a balance after discharge from physical therapy and you are agreeing to continue to pay until balance is paid in full.**

☐ Your Out of Pocket amount has been met for the year. At this time, no payment will be due.

☐ Self-pay. $100 for initial eval and $80 per visit thereafter. Payment is due at time of service.

Payment for Services:

Payment for services, including copays, deductibles, coinsurance and private pay amounts are due at the time services are rendered. For your convenience, we accept cash, checks, MasterCard, Discover, Visa, and America Express. Failure to pay these costs or creating a payment plan may result in canceling treatment. We do ask for a copy of an ID cared or license and your insurance cards so that insurance can be billed with the correct information and to prevent identity theft.

Cancellations or Missed appointments:

It is your responsibility to call **24 hours in advance**, to cancel and/or reschedule the appointment if you are unable make it. Failure to do so will result in a **$33 fee for a regular physical therapy appointment and $50 fee for a physical therapy visit in collaboration with the chiropractor.** By signing this form, you agree to make these payments if you are charged for a No Call No Show appointment.

If any patient and/or personal training member with three missed appointments without a 24-hour notice, will be discharged.

Insurance:

If you have medical insurance and we are contracted with them, we will gladly submit charges to them. We will do our best to get correct insurance information form the companies, however, it is your responsibility to know your insurance deductible, copays and co-insurance amounts and pay all amounts owed to us that your insurance says is your responsibility.

If your insurance requires an authorization, please be aware that this can be a long process. Missing appointments affect end dates and a possibility of lapse in care. Therefore, **if you miss 3 visits during**

Special K Fitness

**your treatment**, we will not request continued authorization and your treatment will be deemed completed.

By signing this form, you authorize payment of medical benefits directly to Special K Fitness.

Divorced Parents of Patients:

The adult who signs and below and on the patient information form accepts responsibility for payment. This office does not send bills or records to both parties involved. We will communicate treatment and payment information with the parent who signs the forms, and you are responsible to communicate with each other.

Release of Information/HIPAA/Notice of Privacy Practices:

By signing this form, you hereby authorize and direct Special K Fitness, Inc. to release to governmental agencies, insurance carriers or others who are financial liable for such professional and medical care, all information needed to substantiate claim and payment. You also acknowledge that you have been informed and shown the Notice of Privacy and Practices brochure which provides information about how we may use or disclose protected health information and your rights under law.

Returned Checks:

A $25 charge will be incurred for any insufficient returned checks. You will be asked to bring cash, certified funds or money orders to cover the amount of the check plus the $25 service charge to pay the balance prior to receiving services from our staff. Stop payments constitute a breach of payment and are subject to the $25 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in San Juan County.

Collection Fees:

By signing this form, you understand that in the event your account Is placed in collection status, any additional fees incurred due to this will be added to your outstanding balance. This includes but is not limited to, late fees, collection agency fees, court costs, interest, and fines. I understand that these additional fees will be your personal responsibility to pay in full.

Accounting Principles:

Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

**PLEASE INFORM THE OFFICE OF ANY CHANGES WITH YOUR INSURANCE, ADDRESS, OR PHONE NUMBERS WHILE YOU ARE A PATIENT.**

_____ _____

*Print Patient Name* *Date*

_____

*Patient signature (or parent/guardian if patient is under 18)*

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