



## FINANCIAL POLICY

Thank you for choosing MTI Physical Therapy. The following is a statement of our financial policy that outlines patient and practice financial responsibilities. Please feel free to contact the billing office at [billing@mtipt.com](mailto:billing@mtipt.com) if you have any questions.

Claims will be filed with your insurance company. By signing below you hereby authorize your insurance benefits to be paid directly to MTI Physical Therapy. You will be responsible at the time of service for all co-pays, co-insurance, deductibles, and services not covered by your plan. Financial responsibility for services rendered rests with you regardless of any insurance coverage.

### CHANGE OF INSURANCE

It is your responsibility to provide accurate and up-to-date insurance information and to alert MTI Physical Therapy of any insurance changes during the course of your treatment. Claims denied due to "untimely billing" will be your responsibility if we were not initially provided with the correct billing information which resulted in late submission.

### INSURANCE COVERAGE RESPONSIBILITY

You are responsible for obtaining and maintaining valid referrals and/or prescriptions for any and all covered services. It is also your responsibility to know the coverage, limitations, and restrictions of your insurance plan regarding physical therapy. Although we will do everything possible to facilitate reimbursement from your insurance company, we cannot guarantee payment of your claim. We file insurance as a courtesy. Insurance follow-up is your responsibility, as is financially responsible for all claims denied by insurance. If your insurance company does not cover physical therapy and you choose to pay out of pocket for treatment, your balance is due at the time of your appointment.

### STATEMENTS

Regardless of any claims pending, if there is an open balance, a statement will be sent to you once a month. Balances are due within 30 days.

### COLLECTIONS AND NSF CHECKS

Delinquent accounts consist of balances left unpaid for 120 days. In the event it should become necessary to forward your unpaid balance to a collection agency, you agree to pay interest and a \$25.00 collection fee. If legal action is taken against your account, you agree to pay all reasonable attorney fees, filing fees, and any other costs associated with this action. Checks returned without sufficient funds will be charged a \$35.00 fee.

### SERVICE AGREEMENT

I hereby give my consent for MTI Physical Therapy to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations. With this consent, MTI Physical Therapy may call my home, mobile phone, or other alternative location, and leave a message on voicemail or in-person in reference to any items that assist MTI Physical Therapy in carrying out treatment, payment collection, and other healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care.

MTI Physical Therapy may mail to my home, or other alternative location, or email to the specified email address, any items that assist the practice in carrying out treatment, payment collection, and healthcare operations, such as patient statements. By signing below, I acknowledge that I have read and understand the information presented above and wish to receive treatment services from MTI Physical Therapy. I agree to be fully responsible for any and all charges for services rendered and not paid by my insurance plan.

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**Signature of Patient or Legal Guardian**

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**Date**



## CANCELLATION AND NO-SHOW POLICY

We are committed to providing you with the highest quality of care and ask that you partner with us by being an active participant in your recovery process. Complying with your plan of care, including attending all scheduled appointments and following your home exercise program, is essential to achieving the best possible outcome from physical therapy. Our Cancellation and No-Show policy is in place to reinforce the need for consistent care in order for your condition to improve.

- **Appointments not kept or canceled with less than 24 hours notice prior to the scheduled appointment time will incur a \$95 cancellation fee**
- **If you are more than 15 minutes late to your appointment, your appointment will be canceled and you will incur a \$95 cancellation fee**
- **If you miss two appointments without proper notice, all future appointments may be canceled**

Appointment reminders are sent as a courtesy. It is your responsibility to know when your appointments are. Cancellations received with more than 24 hours notice from your scheduled appointment time will not be charged. You are expected to leave a time stamped voicemail or email to cancel if you are unable to speak to someone directly on the phone. Cancellation fees cannot be billed to your insurance company and are your responsibility. Missed appointment fees must be paid at the next scheduled appointment.

By signing below, you acknowledge that you have read our policy and understand that your commitment to complying with your plan of care is essential to a successful physical therapy outcome.

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***Signature of Patient or Legal Guardian***

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***Date***

## PRIVACY POLICIES STATEMENT/HIPAA

You have the opportunity to review and question our privacy policies statement at your request. This statement outlines our policies that protect your privacy. We will release your personal health information (PHI) for billing purposes to be reimbursed for services rendered or to facilitate your care with another of your health care providers. If you do not want us to share your PHI for this purpose, you can make this request in writing without penalty or cessation of your care. If you exercise this right, you will be responsible for your balance and it will be your responsibility to submit claims to your insurance carrier for reimbursement.

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***Signature of Patient or Legal Guardian***

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***Date***