ProFormance Rehab

BILLING POLICY

IF WE ARE BILLING YOUR INSURANCE COMPANY, PLEASE CONTACT YOUR INSURANCE FOR THE FOLLOWING INFORMATION BEFORE YOUR APPOINTMENT WITH US.

QUESTIONS THAT NEED TO BE ANSWERED SO THAT YOU KNOW YOUR OUTPATIENT PHYSICAL THERAPY BENEFITS ARE:

Our provider tax ID # is, 91-2112632

- Outpatient physical therapy benefit %: _____
- Do you have a visit max per year? Yes/No Amount? _____
- Are custom orthotics covered on your plan? _____
- Do you have a deductible or co-pay? _____
- Is ProFormance Rehab a provider with your insurance? _____
- Do you need a Prescription or Referral for PT? _____

(MOST INSURANCE COMPANIES REQUIRE A WRITTEN AUTHORIZATION FROM YOUR DOCTOR. PLEASE BE SURE YOU HAVE THIS WITH YOU OR ON FILE HERE.)

PLEASE SIGN BELOW

We are providers for many insurance companies for example, Regence Blue Shield, Blue Cross/Blue Shield, Premera Blue Cross, First Choice, Aetna, Uniform Medical L&I, and all Workers Comp. carriers. If your visit with us is Motor Vehicle Related we will only bill PIP coverage, we do not accept 3rd party claims. For privately insured patients we will bill your primary insurance only. We expect payment within 60 days of the date of service by you or your insurance. **We are not MEDICARE providers** and cannot bill Medicare or supplemental coverage.

Payment for any co-pays or supplies should be paid at the time of your visit. This includes patients who get orthotics. **We accept CASH, CHECK, VISA AND MASTERCARD.**
ProFormance Rehab will charge a $25.00 NSF check fee if necessary.

CANCEL/NO SHOW POLICY:
We ask that you call 24 hours in advance, Monday - Friday, if you need to cancel or reschedule your appointment. Failure to do so will result in a $75.00 charge which is not payable by insurance.

This is a verification of your benefits as described by your insurance company. This is not a guarantee of payment. All payments are subject to the member's eligibility at the time the claim is processed. I understand that ProFormance Rehab, Inc. will bill my insurance company directly, but that I am personally responsible for any co-pays, deductibles, or balances incurred. If my insurance company denies claims or my claims go to medical review, I understand I am financially responsible for all services.

SIGNATURE **DATE**