Thunder Bay Therapy & Sports Medicine Financial Policy

Thank you for choosing Thunder Bay Therapy & Sports Medicine. Our Therapist and Business Office staff works very hard to make sure you have a positive experience with us. As a result of the Affordable Health Care Act, Thunder Bay Therapy & Sports Medicine has determined it necessary to implement the following financial policy.

WE ACCEPT MASTERCARD, VISA, DEBIT CARDS, CHECKS AND CASH

Pay online at: www.thunderbaytherapy.com

Insurance & Insurance Collection

Insurance reimbursement is a long and difficult process for our office. In fact, we have experience with insurers stalling, denying and reducing payments. You must bring all of your insurance cards on your first visit and report any changes to your policy or if a new card has been issued.

Medicare and Medicare Advantage Plans

As a participating provider, we will bill your Medicare carrier. If you have a Medicare Advantage plan, you must present us with the appropriate insurance card along with your traditional Medicare card. You are responsible for your annual deductible and co-insurance which is most often 20%. We are required to collect it. If you have a secondary payer, we will be happy to bill them for you. If a balance remains after we bill Medicare and your secondary insurance carrier we will bill you for the balance.

Co-payments, Co-insurance and Patient Deductibles

All co-payments, deductibles and coinsurances are due at the time of service. Your insurance company deducts this from our payment automatically. Your insurance company's contracting and uniform compliance rules require that we collect these fees.

No Insurance or Services not covered by your Insurance

Patients without any health insurance or patients who have insurance coverage but does not cover rehabilitation services are expected to pay in full prior to or at the time-of-service.

Preauthorization Plans

We cannot determine if your policy requires preauthorization. You are responsible for setting proper referral information and authorizations in advance of your appointment. It is the patient's responsibility to verify with your insurance company that our outpatient physical therapy clinic is enrolled in your insurance plan. You will be responsible for payment for services denied by your insurance company for lack of referral and/or pre-authorization.

Revised May 2014

Workers Compensation and Auto Related Claims

For a workers comp. or auto claim, we will attempt to get preauthorization for care. HOWEVER, an authorization to treat is NOT a guarantee of payment for service. While most are paid without incident, if a company questions your injury, disputes or delays payment on your claim, you are responsible to pay for the balance.

About your information

We require you to bring your insurance card(s) with you on your first visit and keep us informed of any changes in your insurance coverage. Insurance claims denied because you did not provided current and correct information will be due and payable by you. We require that you update your address, telephone and employer information with us whenever there is a change**. If you do not want to disclose your Social Security number, we require payment in full prior to service.** We are not responsible for delinquent accounts due to lack of receipt of statements or other correspondence. Notices are assumed to be acceptable if they are returned to us as unclaimed, forwarding order expired, or otherwise undeliverable.

Returned Check Fee

There is a $25 banking fee for all returned checks. If your check is returned from the bank, we will not accept a check as payment on your account. Future payments must be made with cash, money order or credit card.

Responsibility for Payment

If financial responsibility for your care is assigned to a parent or another person, we will need the consent for service signed by that person and their social security number. This most often occurs with a minor child or adult 25 or under who is on their parents' health plan.

I understand and agree that I am responsible for all charges pertaining to my medical care, regardless of my insurance status. I have read, understand and agree to the Financial Policy. I have completed the patient information forms and the information is true and correct to the best of my knowledge. I will notify you of any changes.

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Signature of Patient or Responsible Party **Date:**

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Printed Name of Patient

Revised May 2014