Dynamic THERAPIES
Occupational Therapy
Physical Therapy
Speech Therapy

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FINANCIAL AGREEMENT

If you have insurance, you are still responsible for payment of services rendered, regardless of any coverage. We will make every effort to keep track of your total visits, but it is your responsibility to be aware of the limitations of your benefits. You are hereby notified in advance that you will be financially responsible in full for any services beyond those allowed or denied for any reason by your insurance carrier. Should you require treatment or procedures beyond the benefit offered by your insurance company, you may negotiate with them for additional coverage. Any extra reports, letters, documentation and or phone calls will be subject to a fee of $110.00 per hour.

We will make every effort to verify your coverage with your carrier and inform you of your deductible, co-payment and co-insurance responsibilities. We verify benefits as a courtesy to our patients, but are at no time to be held responsible if incorrect information has been obtained. Please remember that the information we get from your carrier is only an estimate, and we cannot be sure of the exact amount until we submit a claim and receive an Explanation of Benefits (EOB). Your insurance company will process your claims as in or out of network according to your insurance policy.

Once your deductible, if any, is met, we will collect only your co-payment and or co-insurance and will bill your insurance carrier for the balance. You are responsible for paying your deductible, co-payments and or co-insurance at the time of each visit.

Your co-payment and co-insurance amounts are determined by the insurance company, not by Dynamic Therapies, Inc. A bill for co-insurances incurred is sent out by Dynamic Therapies, Inc. once a month if we do not collect the full amount. Bills should be paid no later than 30 days from date presented. Failure to meet your financial responsibilities in a timely manner will result in termination of treatment. We will not provide services if your bill is not kept current.

We will make every reasonable effort to assist in expediting insurance payment; however, you will be responsible for negotiating any eligibility or payment disputes directly with your insurance carrier.

If your insurance company has not acknowledged any portion of your account within 60 days, the balance is due and payable in full. You will be responsible for the entire debt incurred for services rendered. Accounts remaining outstanding after 60 days will be subject to pay monthly interest at the legal rate. Unpaid accounts will be turned over to collection. If it becomes necessary for the account to be referred to an attorney for collection, you shall pay the actual attorney's fees and collection expenses.

As mentioned above, if services already rendered are denied, or not acknowledged, you will be fully responsible for the fees incurred.

There will be a charge of $50.00 for no show appointments or cancellations with less than 48-hour notification for any reason. You will be personally responsible for any cancellation fees. Cancellation fees are due at the beginning of the session following the no show or cancellation. The cancelation fee will be waived if you reschedule the appointment later that day or within the same calendar week, at any available time and with any available therapist. If you are unable to reschedule the appointment, the cancellation fee will be collected at your next scheduled visit before therapy is provided.

Please note that you are personally responsible for payment for any supplies and or equipment you receive, such as weights, neoprene vest, cervical collars, orthotics, gym balls, tape, etc. Payment for these items is due at the time of service.

I have read and fully understand all of the above information and hereby agree to comply as outlined. If the name of the patient is different from the person signing, I hereby affirm that I am legally responsible for the patient.

_____
Parent or Guardian's Name

_____
Patient's Name

_____
Parent or Guardian's Signature

_____
Date