FINANCIAL POLICY & PRIVACY ACKNOWLEDGEMENT

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. All patients/responsible parties must complete the Patient Information Form and read and sign our Financial Policy prior to any treatment.

ANY AND ALL CO-PAYMENTS REQUIRED BY YOUR INSURANCE COMPANY MUST BE PAID IN FULL AT THE TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER or CARE CREDIT.

Health Insurance: As part of your service, you authorize Progressive Therapy to bill, accept assignment, and attempt to collect from your insurance. Your insurance policy is a contract between you and your insurance company. Progressive Therapy is not a party to your contract. Although we verify your insurance benefits, your insurance company makes the final determination. Please verify benefits with your insurance carrier, as we are not responsible for any incorrect information your carrier has relayed to us. We will bill your secondary carrier as a courtesy. Progressive Therapy is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of the insurance company's arbitrary determinations of usual and customary. You are responsible for any balances within 45 days after your insurance(s) has cleared.

Worker Compensation: We require authorization by your worker compensation carrier prior to your initial visit. However, if your claim is denied, you will be responsible for payment in full.

Personal Injury: Payment of your bill is your responsibility. Payment plans are provided for services incurred. We do not wait for final settlement of any liability case proceedings.

Payments, Finance Charges and Past Due Accounts: If you have a balance on your account, we will send you a statement. Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued, and is considered past due if not paid within thirty (30) days. There is a fee (currently $35) for any checks returned by the bank. A finance charge will be imposed on each service of your account that has not been paid within thirty (30) days of the time the service was added to your account. A FINANCE CHARGE may be computed at the rate of one percent (1%) per month or an ANNUAL PERCENTAGE RATE of twelve percent (12%). The finance charge on your account is computed by applying the periodic rate (1%) to the "overdue balance" of your account. The "overdue balance" is calculated by taking the balance owed thirty (30) days ago and subtracting any payments or credits applied to the account during that time. In the event your account becomes past due, we will take the necessary steps to collect this debt. In the event a legal suit or outside collections are necessary to enforce payment of the account, the patient agrees to pay for all collection fees and attorney's fees, interests and court costs as may be deemed reasonable. You understand that if this account is submitted to an attorney or outside collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Privacy Policy: I am aware that a copy of Progressive Therapy's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law, is available to me. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information _____ _____; however, I authorize the release of information to _____ at any time during my care at Progressive Therapy.

We offer regular text messaging and email to provide helpful information like appointment reminders. Regular text messages and emails are not secured by a technical process called encryption so there may be some level of risk the information could be read by someone besides you. Please let us know if you would not like us to communicate with you by text message or email.

I have read, understand and agree with this Financial Policy. I hereby authorize my insurance (government/private) benefits to be paid directly to Progressive Therapy as accepting assignment. I also authorize release of any medical or other information necessary to process all claims for the duration of my treatment. I, the patient or parent/legal guardian of the patient, authorize Progressive Therapy and its staff to render medical treatment to my child/dependent or myself. I hereby certify that the information given above is true to the best of my knowledge.

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signature of Patient/Responsible Party	**Relationship to Patient**	**Date of Birth**	**Date**

Witnessed by: _____ **Presented on (date and time):** _____