Johnson & Johnson
Physical Therapy

An IPA Physio Clinic

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OUR FINANCIAL POLICY

It is our mission to provide the finest quality healthcare available. In an effort to make our services available to as many patients as possible on an affordable basis this office has established the following financial policies.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

Finance Charges: Any balances not paid after 60 days will accrue interest@ 18% APR.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. We will use all phone numbers/addresses provided on this form to contact you. If we have to refer your account to a collection agency you agree to pay all of the fees involved. If we have to refer to an attorney you also agree to pay all attorney and court fees incurred.

No Show/Cancellation Policy: All cancellations require a 24 hour notice to avoid a *$20.00 per 15 minute cancellation/no show fee*. This charge is your personal responsibility and will need to be paid before your next visit. Exceptions are always made for illness or emergencies. *We charge a $35.00 fee for NSF checks.*

Insurance: Johnson & Johnson Physical Therapy will bill your insurance company as a service to you. Insurance is a contract between you and your insurance company; in most cases, we are *NOT* a party in this contract. It is your responsibility to understand the benefits and policy restrictions that your insurance plan provides. *If your insurance company is not contracted with our providers you agree to pay any portion of the charges not covered by your insurance company, including but not limited to those charges above the usual and customary allowance.*

PATIENT CREDIT CARD INFORMATION:

Name on Card: _____ CVV: _____

Credit Card Number: _____

Exp. Date: (MM/YY) _____ Billing Code Zip: _____

I agree to allow JJPT to keep my Credit Card on file and to charge it at time of service.

Signature: _____ Date: _____

AUTHORIZATION FOR TREATMENT:

I, the undersigned, knowing the patient and/or self is suffering from a condition requiring physical therapy treatment, hereby voluntarily agree to treatment which may be performed on patient and/or self for this condition by the Physical Therapists and students. I have read and agree to all of the above terms for treatment, payments and cancellation/ no show policies.

Signature: _____ Date: _____

IPA Physio
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ADVANCED PHYSICAL THERAPY