Welcome!
Thank you for choosing Valir Physical Therapy as your health care provider!

VALIR PHYSICAL THERAPY – FINANCIAL POLICY

Patient Name:		Patient/Guardian Cell Phone:	
Patient Address:		Patient/Guardian Home Phone:	
Patient City/State/Zip:		Patient/Guardian Work Phone:	
Date of Birth:		Patient Email:	
Social Security Number:		Gender:	☐M ☐F ☐O
Employer Name:		Marital Status:	☐S ☐M ☐W ☐D ☐O
Employer Address:		Emergency Contact Name:	
Employer City/State/Zip		Emergency Contact Number:	

Guarantor Name:		Guarantor Phone:	
Guarantor Address:		Guarantor Date of Birth:	
Guarantor City/State/Zip:		Guarantor Social Security #:	
Guarantor Employer:		Guarantor Employer Address:	
Employer Address:		Employer City/State/Zip:	

Were you involved in an MVA or Personal Injury Accident?		Date of Injury:	
Is your Injury Work Related?		Date of Injury:	
Attorney Name and Law Firm		Attorney Address:	
Attorney Phone:		Attorney Fax:	

*****Have your received Home Health Services in the last sixty days: *** YES // No. If Yes, list the names of Home Health company_____Phone Number_____**

I understand and agree that health and accident insurance policies are a contract between an insurance carrier and the policy holder/insured. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that any amounts that are patient due are due on the date of service. I also certify that the above information is true and correct to the best of my knowledge. I understand that missing a scheduled appointment without providing 24 hour notice to this office will result in a $35.00 charge that will be due at my next appointment. My signature below also certifies that I have received a copy of Valir's Notice of Privacy Practices (effective 01.01.2017).

Patient/Guarantor Signature:	Date:

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INSURANCE INFORMATION We need complete and accurate information about your policy. As a courtesy, Valir will call the provided insurance company to verify eligibility and benefits. However, this will not be a guarantee of eligibility and benefits. Please contact your insurance company with any questions you may have regarding your coverage.

NON-INSURANCE-FEE-FOR-SERVICE (Self-Pay) Fee-for-service is exclusively a non-insurance financial arrangement. Fee-for-service receipts cannot be submitted to insurance for reimbursement. VALIR will discount charges to reflect the current Medicare Allowable Fee Schedule. ***To be eligible for this discount, full payment must be received at the time services are rendered. If full payment for the services rendered is not received at the time of service, the discount will be reversed and 100% of the billed charges will be billed to the patient.***

WORKER'S COMPENSATION Valir requires approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

MEDICARE Valir Physical Therapy participates with Medicare and we bill Medicare as well as any supplemental insurance company provided. Physical therapy is covered service up to $2010 per calendar year. After the initial $2010 has been surpassed, Medicare could cover physical therapy (with proof of medical necessity) up to $3700. You are responsible for any copayment, co-insurance or deductible that applies to your plan.

MINORS ***A parent or legal guardian must accompany the minor patient at the time of the initial visit.*** The parent or legal guardian is responsible for full payment as outlined in the above financial policy. If the parents are separated and both legally responsible for the child, you must provide complete information from both parents. The parent or legal guardian that accompanies the minor patient to the clinic will have full responsibility for the payment should any dispute arise.

PERSONAL INJURY, LIABILITY, AUTO OR INVOLVEMENT OF AN ATTORNEY Patients with a Personal or MVA injury that wish to file their claims with the liable party must provide to us their personal health insurance or med pay insurance from their own motor vehicle insurance policy in addition to the plan information from the liable party. If you do not provide your personal insurance or med pay, you must pay $100.00 per visit.

VALIR will also file a lien for any balance on your account that is not paid at the time services are rendered.

PAYMENT Valir accepts cash, check, American Express, VISA, MasterCard and Discover. There will be a $35.00 service charge for all returned checks. If you have insurance, balances will be considered current from the date your insurance pays its portion. After that, there is a 60-day grace period to pay your portion of the services. After the 60-day period a 1.5% (18% APR) late charge may be assessed on all unpaid balances. We will work with you to set-up a custom payment plan if necessary, please ask. Account balances over 60 days without a payment or payment agreement will be subject to assignment to an out of office collection assistance agency.

COLLECTIONS FOR PAST DUE ACCOUNTS Valir will work with you to avoid sending your account to collections. In the event of default on your account, your account will be turned over to a collection agency. You will be responsible for the unpaid balance plus a collection fee of 23% based on your unpaid balance. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs.

By signing below, I am agreeing that I have read and understand the above outlined financial policy of VALIR and understand my financial responsibility for the services rendered to me by VALIR. I also understand that once I have signed this agreement, I am stating that I agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. I also agree that Valir and their business associates may contact me and all other responsible parties on my account, on our cell phones or mobile devices concerning any and all aspects of my account.

Signature of Patient or responsible party	**Printed Name of Patient or responsible party**	**Date**