

ATLANTA REHABILITATION AND PERFORMANCE CENTER
FINANCIAL AGREEMENT

Payment is expected at the time service is rendered. We accept Cash, Check, and VISA or MASTERCARD.

INSURANCE:

Professional services are rendered and charged to you, not your insurance company. Please understand that payment for services is your responsibility.

We will accept assignment on claims for primary, secondary, and tertiary insurance. All deductibles and fee amounts not covered by insurance are due at the time of treatment unless written financial agreements are made with the Clinic Manager prior to starting treatment.

Please note that any amount collected towards the calendar year deductible or coinsurance is an estimation of your expected responsibility. Your account may reflect a balance after your insurance company has processed your claims.

In order to honor any insurance benefits, you must provide insurance identification cards, and we must be able to verify the current benefits prior to the start of treatment.

Insurance negotiated fees and reimbursements may represent an agreed to fee schedule with your insurance provider that is different from our Usual and Customary Fees and are part of your Insurance Benefit Package. The amounts that you are charged or reimbursed are subject to change at the discretion of your insurance company.

MEDICAL NECESSITY:

If your insurance carrier makes a determination of benefits based on medical necessity, there is no guarantee of payment or reimbursement. Any claims denied as "not medically necessary" will become the responsibility of the patient.

LATE ARRIVALS AND CANCELLATION POLICY:

Please consider your scheduled appointments carefully as we ask for a 24-hour notice of cancellation. Please contact our office if you will arrive late for your scheduled appointment. *Patients arriving more than 15 minutes late may be asked to re-schedule for another day or time.*

OFFICE FEES:

If you present a check for insufficient funds, or place a stop-payment on an issued check, you will be charged a \$25.00 fee for processing.

COLLECTIONS:

Patient accounts sent to a collection agency for delinquent payments will accrue a 38% collection fee.

I have reviewed the above information and understand that payment is determined when claims are received by my insurance company. I acknowledge my portion of the bill and understand my obligation to pay at the time of service.

Patient Signature: _____ Date: _____

Guarantor Signature: _____
(if patient is under age 18)