971 NW Spruce Ave Ste 101 Corvallis, OR 97330 (541)207-3436

Payment Policy/Insurance Coverage Determination (v. 2025-1)

Patient Name: _____ DOB:___/___/_____ Date: _____

Physical Therapy must be MEDICALLY NECESSARY in order to be covered by insurance. Physical Therapy is billed in 15 minute increments dependent upon the treatment provided. Each could have a different cost. Please talk with your therapist if you have concerns about the cost of service. We can customize your plan of care to be cost effective.

Payment is due at the time of service. We are not in the business of extending credit to customers. All deductibles, co-pays, co-insurance, and balances due, **both current and prior, are due at the time of service.** This arrangement is part of your contract with your insurance company. Failure to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. Preferred payment methods are cash and checks. Payments made with a credit card are subject to a 2.9% service charge. A 3.5% service charge will be charged for all balances paid when the card is not present (online, phone or mail-in transactions).

You are responsible for all charges not paid by your insurance. A per annum fee of 18% will be assessed to any balance more than 30 days past due. There will be a $35 fee for returned checks. Accounts 90 days past due will be referred to collections. Patients will be responsible for collections costs, attorney and court fees.

Knowing your insurance benefits is YOUR responsibility. Your insurance coverage is a contract between you and your insurer. As a *courtesy* to you, we will contact your insurance plan to determine eligibility & coverage of therapy services, but the insurance plan does not guarantee the accuracy of the information provided.

****This coverage determination does NOT guarantee payment by your plan.****

_____ **Private Insurance:** We have contacted _____ ID # _____ to verify your therapy benefits. The following information was provided by your insurance company:

__ Prior authorization for physical therapy is required by your plan:_____
__ The maximum benefit for Physical Therapy is ___ visits or $ _____ per benefit period.
other: _____
__ You have a deductible of $_____ of which $_____ has been met.
__ You are responsible for _____% of allowed charges.
__ You are responsible for a co-payment of $_____ per visit.
__ Your out of pocket maximum is $_____ of which $_____ remains / has been met to date.

_____ **Medicare with Supplemental Insurance (_____):** Medicare pays 80% of allowed charges for medically necessary services after your deductible is satisfied for the year ($257 for 2025). Most supplemental plans will pay the remaining 20% after deductible.

_____ **Medicare only:** (No Supplemental Insurance) Medicare pays 80% of allowed charges for medically necessary services after your deductible is satisfied for the year. ($257 for 2025) You are responsible to pay 20% of allowed charges. **The 20% Co-Insurance is due at the time of service.**

_____ **Medicaid:** Services must be considered medically necessary. Authorization may be required based on diagnosis, annual visit limits or if you are enrolled with a CCO (Community Care Organization/Managed Medicaid). You are responsible to notify us in a timely manner about changes to your Medicaid coverage or enrollment.

_____ **Workers Compensation:** Authorization is required from your adjuster for treatment. Most worker's compensation carriers have up to 90 days to accept a claim. You, the Patient, will be personally liable for any services deemed non-compensable by the Worker's Compensation carrier or MCO. Your health insurance can be billed in case of a denial. Prior authorization may be required by your private insurance.

_____ **Private Pay/Cash Pay**: **Payment is due in full at the time of service.** For patients with MVA or other liability insurance claims, **it is your responsibility to file claims with the insurance company.** Bills will be printed for you each visit. We will not send bills to an attorney for your liability claim.

We encourage you to call your insurance carrier to verify your eligibility and coverage as described above. If you make any changes to your health insurance policy or mailing address, it is your responsibility to notify us. You are responsible for any charges your insurance does not cover. This document shall remain valid for the entire episode of care for which you are seeking treatment. Please sign below to acknowledge you have read and understand the payment policy and agree to abide by its guidelines:

Patient signature: _____ Date: _____