Sands Point Physical Therapy

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Rockaway Park, NY 11694
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www.SandsPointPT.com

Financial Policy Statement

Sands Point Physical Therapy will bill your insurance carrier as a courtesy to you. Patient responsibility is explained to you and co-payments or other payments responsibilities are due at each visit. Coinsurance/deductible will be billed to you after we receive payment from your insurance company.

It is your responsibility to inform the front desk of any policy changes in your insurance immediately. Many of the insurances require prior authorization for physical therapy. In the event of a policy change it may be required to obtain prior authorization. This is one of the very important reasons for immediate notification of policy change. **In the event your insurance company requests a refund for payments made, you are responsible for the amount of money refunded by insurance company. In the event your insurance company reimburses payment directly to your home, payment must be signed over to Sands Point Physical Therapy.** Estimated coverage information is provided to you as a courtesy. It is not intended to release you from any patient responsibilities. We recommend checking your own benefits with your insurance company.

Workers Compensation and No Fault patients: if your case is closed or coverage is no longer effective it is your responsibility to submit a copy of your commercial insurance card to the front desk or the billing department. Check with the front desk or billing department to see if Sands Point Physical Therapy is a provider with your commercial insurance plan. If you do not have other medical coverage you are responsible for payment of your bills.

Cancellation/No-Show Policy

Our office may charge you a $15 fee for missed appointments with less than 24 hours notice. Our office does acknowledge extenuating circumstances and will take that into consideration when applying this fee. No insurance company will be billed for this fee, the responsibility is solely yours.

The above information has been explained to me and I understand my responsibility and payment of my account.

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Patient/Guardian/Responsible Party **Date**