EW MOTION THERAPY MGMT
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EW MOTION THERAPY LLC
UPDATED FINANCIAL AGREEMENT

EW Motion Therapy LLC, its entities, and its affiliates are committed to providing you with the best care possible. This goal is best achieved if everyone is aware of the financial policy, which is an agreement between the Physical Therapists of the practice and the patient. Your clear understanding of the financial policy agreement is important to our professional relationship. **In 2023 we have updated our financial agreement to reflect recent changes in our collection policies. To ensure both existing and new patients are aware of the updates we ask you to please initial after each section of the document to indicate that you understand and agree to comply with our current financial agreement.**

THE FINANICAL AGREEMENT

We must emphasize that as your physical therapy providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from THE DATE SERVICES ARE RENDERED. Therefore, it is necessary for you to know what benefits your insurance plan provides for you. It is your responsibility to contact your insurance company to find out your physical therapy benefits.

PATIENT'S or AUTHORIZED AGENT'S INITIALS _____

PAYMENT

Payment is expected at the time of service. This is an insurance company rule. Deductibles, co-payments, and/or co-insurance are your responsibility and will be billed to you by our office. All insurance carriers have a fee schedule from which they will reimburse. Patients are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason, except where prohibited by law or prior contractual agreement. You now have the option to save a credit card on file that can be automatically charged after each of your appointments and a receipt will be emailed to you.

☐ **Yes, I would like to save a credit card on file to be automatically charged after my visits.**

☐ **No, I would not like to save a card on file and I commit to paying my balance in person after every visit.**

EW Motion Therapy LLC, its entities, and its affiliates accept cash, personal checks, VISA, MasterCard, and Discover Card. We reserve the right to charge a $30 service charge for returned checks. Patients with an outstanding balance more than 90 days overdue must make arrangements for payment prior to scheduling appointments.

PATIENT'S or AUTHORIZED AGENT'S INITIALS _____

VISITS COVERED BY INSURANCE

It is the patient's responsibility to provide us with current insurance information and to present an active insurance card at each visit. Most insurance plans require a referral from a physician in order to cover services for physical therapy. It is the patient's responsibility to contact his insurance company to find out this information.

PATIENT'S or AUTHORIZED AGENT'S INITIALS _____

CANCELLED APPOINTMENTS

If you are unable to keep your scheduled appointment, please call our office at least 24 hours before your appointment to reschedule. This will allow time for us to provide that time slot to another patient. **We reserve the right to charge $55 for appointments that are not cancelled at least 24 hours in advance.**

If you do not show up or if you do not cancel your scheduled appointment in advance for three visits in a row, we reserve the right to cancel your remaining appointments from the schedule & to charge $55 for each previously missed appointment.

PATIENT'S or AUTHORIZED AGENT'S INITIALS _____

MORE INFORMATION

Please call if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having trouble paying your bill, please discuss your situation with us. Satisfactory arrangements can almost always be made. Financial considerations should never prevent patients from receiving the care they need at the time it is needed.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY EW MOTION THERAPY LLC, ITS ENTITIES, AND ITS AFFILIATES. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTION IN ADDITION TO THE ORIGINAL AMOUNT DUE. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

_____	_____	_____
PATIENT OR AUTHORIZED AGENT SIGNATURE	**PATIENT'S NAME (PLEASE PRINT)**	**DATE**