1389 Huffman Park Dr, Suite 160
Anchorage, AK 99515
P: (907)885-0515
F: (907)290-3193
info@pointnorthpt.com

FINANCIAL POLICY

Welcome to Point North Physical Therapy. To make ensure your rehabilitation and treatments with Point North are as stress free as possible we have established a clear financial policy. Below outlines information specific to all aspects of the financial responsibility associated with your recovery. Please read carefully and sign where indicated. A copy of this form will be issued to you upon request.

All patients are encouraged to contact their insurance provider for verification or clarification of allowed benefits. Knowing your insurance benefits is your responsibility. In most cases, Point North will bill your provider, however any account balance incurred with Point North is legally your responsibility. The adult, parent or legal guardian accompanying a minor dependent is financially responsible for all services rendered by Point North and agree to all terms listed herein.

If Point North will be billing a workers' compensation carrier or motor vehicle insurance provider, it is imperative that we receive your claim information as quickly as possible. We will also require a copy of your personal insurance information if your workers' compensation or motor vehicle accident claim is denied.

Should your account become more than 30 days overdue we charge 9% finance charges per month of the incurred balance. After 90 days delinquency our policy is to report your account to a credit bureau, then turn the account over to a collection agency. Any legal fees paid to secure overdue balances will be added to your account and treatment with our facility may be terminated.

Terms of Agreement

I, the undersigned, hereby agree with the following:

- All co-payments and deposits for deductibles and coinsurance plus any accrued balance on your account must be paid at the time of service. This arrangement is part of my contract with my insurance company. Failure on the part of Point North to collect co-payments and deductibles from patients may be considered fraudulent. I agree to pay my estimated payment plus accrued balance at each visit.
- I am aware that some, and perhaps all, of the services/equipment I have received may be non-covered, denied by my carrier or not considered reasonable or necessary by Medicare or other providers. I understand that I am financially responsible for all charges not paid by my insurance company.
- I will present my ID and a copy of a current, valid insurance card to provide proof of my existing insurance coverage. I will notify Point North of any change in my information, including but not limited to, address, phone number or insurance coverage.
- My insurance company may need for me to supply certain information directly. It is my responsibility to comply with all requests. I am aware that insurance coverage does not guarantee payment of services.
- I certify that I (or my dependent) have insurance coverage as provided to Point North and assign directly all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by my insurance provider. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
- I understand that I may be assessed a 9% monthly finance charge for balances accrued over 30 days. These charges are my responsibility and not covered by my insurance.

______________________________ __________________

Signature of Patient or Responsible Party Date