Patient Financial Responsible Disclosure Statement

All charges for services rendered are due and payable at the time of service

We have contracts with many insurance companies and we bill them as a service to you. If your insurance company or government entity declines to pay us for any reason, you are responsible for payment.

The person signing as the patient and/or Responsible Party must:

- Inform Northwest Physical Therapy d.b.a. Willow Creek Physical Therapy and/or Victor Physical Therapy of the current address and phone number for the patient and the Responsible Party
- Present all current insurance cards, VA authorization paperwork, motor vehicle accident and workman compensation information at the first office visit
- Pay any required co-pay at the time of each visit
- Pay any additional amount owed within 30 days of receiving a statement from our office. (When our billing department receives an explanation of benefits (EOB) from your insurance company, any additional amounts you need to pay will be billed to you)

Returned Check Policy

If you pay by check for services and the check is returned for NSF (non-sufficient funds), Account Closure (AC) or Refer to Maker (RTM), the patient or patient's Responsible Party will be responsible for the original check amount in addition to a $30 service charge.

Non-Payment on account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's Responsible Party understand that Northwest Physical Therapy d.b.a. Willow Creek Physical Therapy and Victor Physical Therapy reserve the right to disclose all relevant personal and account information necessary to an outside collections agency for collection of payment for services rendered. The patient or patient's Responsible Party understand they are responsible for all costs of collection including, but not limited to, all court costs, attorney fees and collection fees in addition to the outstanding balance. The collection agency may attempt to contact your home and/or mobile/cell phone by an automated dialer system.

By signing below, you agree to accept full financial responsibility as a patient and/or legally responsible party for who is receiving physical therapy services. Your signature verifies you have read the above disclosure statement, understand your responsibilities and agree to these terms.

Patient Name (please print)____

Responsible Party Name (please print)__________________________________

Responsible Party Signature_____________________________ Date____________

Please see other side