nworthomassage

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# Financial & No-Show Policy

Your insurance policy is a contract between you and your insurance company. We are not a party to the contract. We will however bill your insurance. Please be aware that some and perhaps all of the services provided to you may not be covered and/or not considered medically necessary under your particular insurance plan. You will be responsible for all expenses excluded under your benefit plan. We only provide service if we consider it medically necessary; therefore, if your insurance company arbitrarily determines that a service we have rendered to you is not medically necessary, you will be responsible for the bill.

***ALL co-payments are due at the time of service (TOS)***. A ***$20 billing fee may*** be assessed if you fail to pay your co-pay at TOS. If you have acquired a bill that your insurance has either decided not to pay or has only paid partially, you are FULLY RESPONSIBLE for the remainder. Bills need to be paid in a timely manner***. Any bill not paid within 30 days will incur a 1% interest rate added to each month.***

We bill MVA with a personal injury claim (PIP), if requested, but you are required to provide us with your medical insurance as secondary coverage. If your claim or re-opening application with the Department of Labor and Industries (state or self-insured) is denied or rejected you are responsible for your medical expenses.

We will bill your primary and secondary insurance as needed. However, any other billing is your responsibility.

**No-Show Policy**
Should the circumstance arise where you need to cancel or reschedule an appointment a 24-hr notice is required. Failure of giving the required notice will result in the appointment being registered in the patients chart as a no-show and a cancellation fee of ***$50.00***. You are personally responsible for this fee, and its payment is required before your next scheduled appointment. Please take note, insurance companies ***ARE NOT*** responsible for the no-show fee and will not cover it. Also, if you are a L&I or motor vehicle patient continual no-shows can result in non-payments of existing claims.

********IF YOU ARE SICK WE DO ASK FOR YOUR HEALTH AND THE THERAPIST'S CONSIDERATION THAT YOU RESCHEDULE YOUR APPOINTMENT TIME TO A LATER DATE*****

By signing below I acknowledge and agree to receive and pay for all therapy services as outlined. I assume financial responsibility for any balance due, attorney or collection costs and for services rendered that are not covered by my insurance due to lack of prior written referral, authorization, or no show. I authorize the release of any medical information required for this claim to be processed. I authorize NW Orthopaedic Massage to contact the Insurance Commissioner to aid in getting payment, if necessary. I further authorize my insurance benefits be paid directly to NW Orthopaedic Massage.

Patient Name: _____

Patient Signature: _____ Date _____