

Financial Policy

PT Northwest thanks you for choosing us to meet your physical rehab needs. Our independent practice group has served the Willamette Valley for over twenty-five years. As a courtesy to you, we will bill your primary and secondary insurance company. Although we contact your insurance company to verify benefits and coverage, the information we receive is not a guarantee of payment. You should contact your insurance carrier if you have any questions regarding your benefits or coverage.

To efficiently process your claim, we need accurate information about you and your insurance company. If your insurance information changes please let us know as soon as possible. You will receive a monthly statement that will reflect any payments or contractual write-offs applied to your account. You are responsible for any balances remaining including any charges denied by your insurance company or applied to a deductible. If your account is turned over for collection, you will be expected to pay this balance prior to scheduling any further appointments with us. You may also be required to make a payment at each visit thereafter. We reserve the right to charge interest at a rate of 12% per year on any patient balance that exceeds 120 days.

If we are billing a third party liability claim for you, we must be able to verify that it is a valid claim. If we are unable to obtain verification, we will expect payment at the time of service. We will be happy to bill your private insurance carrier, but you will be responsible for payment if these charges are denied.

Many insurance plans require patients make a copay for each visit. Copays are due at the time of service. As a convenience to our patients, we accept Visa, MasterCard, Discover and American Express.

If you have any questions regarding your bill, insurance coverage or if you have a financial need and would like to make arrangements for payment of your account, please feel free to call our billing department at 503.540.8701.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE FINANCIAL POLICY.

Patient Signature _____ Date _____