RIO RANCHO PHYSICAL THEREAPY
PATIENT FINANCIAL RESPONSIBILITY FORM

The patient (or patient's guardian, if a minor) is ultimately responsible for payment at the time of service for his/her treatment of care.
Patients are responsible for co-pays, co-insurance, deductibles, and all other treatments not covered by their insurance plan, which is due at the time of service.

If your insurance has changed or you have more than one policy the patient is required to provide us with the correct and updated information and will be responsible for any charges incurred if the information provided is not correct or updated. We will not bill secondary insurance if information is not received on first visit.

Common Reasons for insurance claim denials include but are not limited to:

- Insurance not in effect at the time of service
- Patient has NOT met policy deductible
- Coverage by more than one plan in which coordination of benefits has not been arranged
- Policy maximum has been reached
- Medical services rendered is not covered by the insurance policy
- If you fail to disclose auto 3rd party claim. (auto related injury)
- Pre-existing medical condition(s)

*****If any changes in your insurance information coverage is not provided or received within the insurance carriers timely filing period, the patient will become responsible for any balance on the account.*****

Workers Comp/ Auto
We cannot file claims to worker comp program unless your adjustor has authorized your treatment. We can file automobile-related accident claims only if we are going through **YOUR** own auto insurance.
We DO NOT bill 3rd party claims nor do we accept letter of protection.

Self Pay
Full payment is due at the time of service.

Balance Due
We will send a statement to your billing address notifying you of any balance due. Any unpaid balance is patient's responsibility and payment in full is due upon receipt of the statement. Payment not made within **60** days of statement date will be considered delinquent.

IF YOU ARE UNABLE TO PAY THE BALANCE DUE IN FULL, YOU MUST CONTACT OUR OFFICE TO DISCUSS POSSIBLE PAYMENT OPTIONS WITHIN THE 30 DAYS.

I understand and agree that my account will be considered delinquent and sent to RRPT, Inc.'s collection attorney if payment arrangements are not made upon demand. I understand and agree that interest will be charged on all accounts at 18% per year, from 30 days after last date of service. I do hereby to the above payment conditions and accept responsibility for payment of treatment costs, all attorney fees, plus other collection costs and charges necessary for collection of any amount not paid when due.

I have read, understand, and agree to the provisions of the Patient Financial Responsibility Form.

***Your estimated co-pay / co- insurance _____ per visit. After deductible _____ has been met.**
(May change after receipt of first EOB from plan)

Signature of Responsible Party: _____ Date: __/__/__