Financial Agreement

I _____, acknowledge I am seeking treatment from Momentum Physical Therapy. I understand Momentum Physical Therapy will submit medical claims to my health insurance(s). I am aware that any remaining balance or denials determined by my insurance plan are my financial responsibility. Furthermore, I acknowledge that if I fail to provide accurate and current insurance information, **all** denied claims will be my financial responsibility.

Name of Insurance(s):

1. Primary: _____
2. Secondary: _____
3. Tertiary: _____

Based on my insurance coverage, Momentum Physical Therapy will collect any estimated out of pocket costs **at the time** services are rendered.

REFERRALS: Some managed care plans require written referral forms from your primary care physician for each visit to a specialist. It is the patient's responsibility to make sure that Momentum Physical Therapy has a valid referral form before each visit. These forms cannot be issued retroactively. Failure to obtain a referral may drastically reduce your benefits/coverage with your insurance carrier.

APPOINTMENTS: All appointments require 24-hour notice for cancellations. Patients who are more than ten (10) minutes late for a scheduled visit may be asked to reschedule at the discretion of the therapist. **A $40 fee will be charged for all NO SHOW/NO CALL visits as well as SAME DAY CANCELLATIONS**.

RETURNED CHECK FEE: I, the undersigned, agree to pay a fee of $36.00 for any check returned by my financial institution regardless of reason.

DELINQUENT ACCOUNTS: Should your account balance become delinquent, you will be responsible for all collection costs and 28 percent of the principal amounts in collections cost/attorney fees.

I have read and understand the above financial agreement and hereby authorize Momentum Physical Therapy to secure the payment for my treatment.

Patient Signature: _____ **Date:** _____
(Parent or Guardian if patient is a minor)