PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Wind River Physical Therapy LLC
150 Lincoln Street Lander, WY 82520
307-335-5188

Thank you for allowing Wind River Physical Therapy LLC to assist you with your rehabilitation. In the interest of good healthcare practices, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward helping you heal. Our goal is to make the financial aspect of your recovery as stress-free as possible.

As a courtesy to you, we will bill your insurance. If there are any changes in your insurance, please let us know immediately so we can submit your claim properly. We cannot accept responsibility for collecting on an insurance claim after 60 days or for managing a disputed claim. Insurance reimbursement is a contract between you, your employer and/or your insurance carrier. You are responsible for any charges, or portions of charges that your insurance does not pay.

Co-Pays are due at the time of service. You will begin receiving monthly statements with any balances after your insurance company has been billed. If you have any questions about your charges or statement, please contact Patient Account Services at 307-335-5188. The balance of the account is due within thirty (30) days.* (unless a payment plan is set up)

Please contact the clinic if you are not able to keep your scheduled appointment. There will be a $50.00 charge for failure to call and cancel your appointment prior to the scheduled time. Appointments should be cancelled at least 24 hours in advance. We see our patients in 1 hour time slots so to fill your slot we need advanced notice. Three no shows will cause you to be discharged from physical therapy.

I,_____ the undersigned:

_____I Have insurance coverage, and authorize direct payment from my insurance carrier to Wind River Physical Therapy LLC. Note: You are responsible for knowing your coverage benefits. Wind River Physical Therapy LLC will make every effort to inform you if a supply or service is not covered by your insurance. Average treatment costs per visit are $150-$200.

_____ I do not have insurance coverage and understand that I am responsible for payment of 100% of all charges.

_____I have a work comp claim and my number is _____.

I have read this credit policy and understand that regardless of my insurance coverage or lack thereof, I am responsible for payment of my account. IF IT BECOMES NECESSARY FOR THIRD PARTY COLLECTION, I AGREE TO PAY FOR ALL COSTS AND EXPENSES INCLUDING REASONABLE ATTORNEY FEES. This will ensure that our responsible patients will not be penalized to cover costs incurred by those who do not pay on time.

PRINT PATIENT NAME: _____

PATIENT SIGNATURE: _____DATE: _____

PARENT/GUARDIAN must sign if patient is under 18 years of age
SIGNATURE: _____DATE: _____

*** Payment plans are available by request based on your current financial situation. * Please ask the receptionist if you wish to have a copy of this form.**