**Financial Policy**

We, Hamilton Physical Therapy, LLC (HPT), are dedicated to providing our patients with the best possible medical care. When it comes to specific needs, we are here to work with you. In order for HPT to avoid any misunderstandings regarding payment for medical services received, we provide you with the following information:

Our office participates with a variety of insurance plans. Being a member of one of those plans will require our business office to submit a claim for services.

**It is the patient’s responsibility to:**

* Provide us with current insurance information, including social security number.
* Bring their insurance card and driver’s license to the first appointment.
* Be prepared to pay their co-pay at each visit. Pay any balance not covered by their insurance plan, including deductibles.
* Provide worker’s compensation or accident related coverage, including the claim number, to allow us to bill the proper location for their services.

If a patient is a minor (18 years or younger), the parent/guardian will be required to sign below. The parent/guardian or unaccompanied minor will be responsible for payments due at the time of service.

Payment for services received can be paid with Cash, Check, Credit/Debit Cards or Samsung Pay. Let us know if you have any questions regarding your insurance, we are happy to assist you.

Hamilton Physical Therapy, LLC firmly believes that good communication and understanding is fundamental to a good relationship with our patients. Any questions concerning our Financial Policy should be directed to the front office. We are always here to help.

In order to assist you in your knowledge of your insurance policy:

**Primary Insurance:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber I.D. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IN/OUT of Net.? \_\_\_\_\_\_\_\_\_\_\_

In-Net. Deductible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Out-of-Net. Deductible: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Deductible Met? \_\_\_\_\_\_\_\_\_\_

In-Net. Copay/Coinsurance: \_\_\_\_\_\_\_\_\_\_\_ Out-of-Net. Copay/Coinsurance: \_\_\_\_\_\_\_\_\_\_\_ Out-of-Pocket Expense: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Out-of-Pocket Expense Met?\_\_\_\_\_\_\_\_ Visits Allowed: \_\_\_\_\_\_\_\_\_\_ Auth. Required? \_\_\_\_\_\_\_ Auth. #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Information**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**I have hereby read and understand the above text. I authorize release to any third party, such as an insurance company or governmental agency, any medical information when such material is required for consideration or payment. I assign all payments for medical services for myself and/or dependent to Hamilton Physical Therapy, LLC. I agree to pay for any charges not covered by my insurance.**

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**Patient/Guardian Signature Date**