Payment policy of Tuckey and Associates Physical Therapy, LLC

Patients are responsible for payment for all services rendered them by Tuckey and Associates Physical Therapy, LLC. We will bill your primary insurance carrier as a courtesy to you. The carriers contracted rate will be accepted from your primary insurance carrier only if we have a signed contract with that carrier to accept the negotiated rate. You are personally responsible for any deductible, co-pay and or co-insurance payment. These are due in full at the time of service. **If payment from the insurance carrier is denied or if payment is not made within 90 days, the balance for that billed amount becomes due and payable by the patient.** When a patient is a minor, the parent/ guardian assumes financial responsibility.

In the case of automobile injury Tuckey and Associates Physical Therapy, LLC will bill the patients PIP directly. When the patient is examined or treated for a condition that may be the result of an accident or injury, if litigation is involved, or if the injury is covered under Workman's Compensation, it is ultimately the obligation of the patient to pay all outstanding balances in full and will not in any way be contingent upon the outcome of any claim for injury.

I understand and accept that it is ultimately my obligation to pay for any and all physical therapy charges for which I am billed by Tuckey and Associates Physical Therapy, LLC. I understand that I am also responsible for paying any and all fees associated with the collection of my outstanding balance should legal counsel or collection agency become necessary.

***** If you are unable to keep a scheduled appointment, please give our office 24 hours' notice to fill that appointment. Failure to do so will result in a <u>$40</u> cancellation charge, payable by you, not your insurance carrier. FAILURE TO SHOW FOR A SCHEDULED APPOINTMENT WILL RESULT IN A <u>$40</u> FEE PAYABLE BY YOU BEFORE TREATMENT RESUMES. IF YOU ARE SCHEDULED FOR AN HOUR THE NO-SHOW FEE DUE BY YOU IS <u>$80.</u> Multiple no-show visits or last-minute cancellations may result in discharge from the practice.**

I hereby acknowledge that I have read this contract in its entirety and have had all of my questions concerning the above policies answered. I fully understand this contract and agree to its terms.

____________________________________ __________________

Patient/ Responsible Party Signature Date