



Adams & Giddings  
Physical Therapy, PC

Sport & Spine Specialists

## **Statement of Financial Policy**

Welcome to **Adams & Giddings Physical Therapy, P.C. (AGPT)**. We assure you that you will receive the very best care available for your condition. The following information will familiarize you with the financial policy of this office and how your medical bills will be handled. A copy of this form is available upon request.

**Explanation of Insurance Coverage/Insurance Billing:** We will be happy to file your insurance claims for you and agree to your insurance company's fee schedule when processing their payment. Regardless of your insurance coverage, your policy is a contract between you and your insurance carrier. You are ultimately responsible for payment which may include a co pay, coinsurance, and/or deductible. If your claim is denied due to lack of coverage or your insurance company does not pay for the services rendered, you will be responsible for the entire balance on your account.

**Payment Arrangements:** Verification of your insurance benefits indicates you are responsible for a \_\_\_\_\_ deductible that has/has not been met and a payment of \_\_\_\_\_ be made at each visit. Your co pay/ coinsurance is \_\_\_\_\_ each visit. **Your portion of the bill must be paid within 30 days of the billing date.** Any unpaid balances will be considered past due and will be sent to collections after 75 days. We accept cash, VISA, MasterCard, Discover or check<sup>1</sup>.

**Appointments:** We realize that on rare occasions you may need to reschedule or cancel an appointment. We request that you contact our office as soon as possible if you are unable to attend a physical therapy session. You can contact us at (970) 416-8342 to cancel or reschedule. Please leave a message on our voicemail after hours, if necessary.

**Authorization for Payment/Assignment of Benefits:** I hereby instruct **Adams & Giddings Physical Therapy, P.C.** to bill my insurance company for services rendered and said insurance company to make direct payment of medical benefits to:

**Adams & Giddings Physical Therapy, P.C.  
702 W. Drake Road, Bldg E, Ste A  
Fort Collins, CO 80526**

**Release of Information:** I authorize any physician, hospital, school, referring agency or other person who has records pertaining to treatment at AGPT to release such records, upon request, to our facility. Furthermore, I authorize AGPT use or release of any of my records it may have to third party payers, government agencies, healthcare providers, or any other organizations that may assist them in meeting my healthcare needs. I may revoke this authorization in writing at any time and that such revocation will be effective as of the date the written revocation is received by AGPT.

**Privacy Notice:** You, the below-named patient, are entitled to certain privacy rights regarding protected health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPPA). During the course of treatment, we collect personal information about you that is necessary for treatment. We treat this information as confidential and realize the importance of protecting that information. A complete copy of our HIPPA Privacy Practices is available upon request.

**I have read the above information and by signing below consent to financial responsibilities, release of information, assignment of benefits, and acknowledgement of privacy practices.**

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Patient's Signature

Date

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<sup>1</sup> A fee of **\$25.00** will be charged on all returned checks.