Progressive Therapy Associates
improve. empower. renew.

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Clinic Policies

At Progressive Therapy Associates, we value and appreciate your business. We are committed to providing exceptional care to our patients and their families. The following policies are in place to ensure that our services are provided in a timely manner.

Cancellations:
When a patient cancels or misses an appointment without adequate notice, this prevents another patient from receiving the care that they need.

Since an appointment is a reserved time for you, a credit card is required on file for payment, if a 24-hour advanced notice is not given for the following services:

Evaluation appointment: $90.00
Therapy appointment: $30.00

If a patient cancels or misses an appointment, without the 24-hour notice three times in a calendar year, this may result in discharge from our clinic.

Reminders:
Appointment reminders are sent via text message or email the day before the appointment. Please write the preferred contact information in the space provided below to receive reminders.

Text: _____

Email: _____

Insurance Plans:
Progressive Therapy Associates accepts insurance from several different companies. It is the patient's responsibility to provide us with current insurance card information. If the insurance card is not presented at or before the time of the evaluation, the account will be placed on a private pay status until the insurance information is obtained.

Co-pays must be paid at the time of the visit. Co-pays will not be billed to the patient's account. After receipt of payment from insurance, co-insurance and deductible balances will be billed to the patient address that is on file.

It is the patient's responsibility to understand the limitations of their health insurance policy. We do contact insurance prior to scheduling an evaluation to verify benefits, but this is not a guarantee of payment. We do file with insurance promptly after each appointment. If the insurance company determines that they will not pay claims that are submitted, it is the patient's responsibility to pay for any remaining balance.

We will contact the patient's primary care provider to obtain a medical order to have on file. Some insurance companies require orders to determine medical necessity and pay claims that are submitted.

Patient Balances:
If the patient does not have health insurance, private pay is an option. We accept cash, credit card, debit card, and checks. In the event of a nonsufficient funds check (NSF), a $30.00 fee will be added to the balance due.

If the patient's balance exceeds $500.00 and regular payments are not received; we will be unable to schedule additional appointments.

If there is an unpaid balance at the end of the billing cycle, we may apply a **$5.00 late fee** to the account per month. If a payment is made, but it is insufficient to fully pay both the late fee charge and the principal amount, the payment is first applied to the late fee and the remaining is applied to the principal balance. If the account is turned over to collections, a fee will be added to the account along with any attorney fees and/or court costs that may be necessary for recovery of the outstanding balance.

The payer (patient, legal guardian, guarantor or payee) is financially responsible for payments for any remaining balances. This person may be different than the insurance policyholder. In cases where a written court order allows payment for medical costs associated with the patient, it is the responsibility of the payer to obtain reimbursement from the other party involved.

Patient Agreement:

I have read, understand, and agree to the above clinic policies for Progressive Therapy Associates. I understand that charges not covered by insurance, as well as applicable co-payments and deductibles are my responsibility. I authorize Progressive Therapy Associates to release information required to process my claims and that benefits be paid directly to Progressive Therapy Associates.

I authorize, Progressive Therapy Associates to keep my signature on file and charge my credit card for cancellation fees as indicated above.

_____
Print name of patient

_____ _____
Signature of patient/responsible party Date
(patient, legal guardian, guarantor or payee)